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George Isham, M.D.  
Elizabeth McGlynn, Ph.D.  
Co-Chairs, Measure Applications Partnership  
C/O National Quality Forum  
1030 15<sup>th</sup> St NW, Suite 800  
Washington, DC 20005

***RE: January 2016 Measure Applications Partnership Pre-Rulemaking Draft Report***

Dear Drs. Isham and McGlynn:

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the National Quality Forum (NQF) Measure Applications Partnership (MAP)'s 2016 Considerations for Implementing Measures in Federal Programs draft report. The AAMC is a not-for-profit association representing all 145 accredited U.S. allopathic medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

The AAMC appreciates the MAP Workgroups' thoughtful review and discussion of the measures under consideration (MUC). The following are the AAMC's high-level comments on the preliminary MAP recommendations for both hospitals and clinicians:

- Regarding the physician measures under consideration, the AAMC recommends that the MAP emphasize the importance of having measures available to physicians to report that are meaningful. Certain types of measures might be more appropriate for certain physicians than others, and some specialties have very few measures available to report. Therefore, we are pleased to see that CMS and the MAP are continuing to address measurement gaps and to improve the existing set of measures. As physicians transition to the MIPS program and alternative payment models, CMS should take steps to limit administrative burden associated with reporting quality measures under these programs. Reducing burden in measurement reporting and documentation requirements will enable physicians to focus on high quality patient care.
- For the hospital measures, the AAMC strongly believes that certain accountability measures must be adjusted for sociodemographic status (SDS) before being included in the Medicare quality reporting programs, be NQF-endorsed prior to MAP review, and be included in the Inpatient Quality Reporting (IQR) program for at least one year before being considered in a performance program by the Workgroup.

- Finally, the AAMC believes that the MAP Workgroups should review measures in the Medicare programs holistically in order to ensure that new measures add value, are useful for consumers, and promote alignment, while also considering the burden to reporting these measures for providers. While only new or revised measures are reviewed by the MAP, a comprehensive review can only occur when the committee considers the data collection burden imposed by existing measures.

### MAP Clinician Workgroup Comments

The draft MAP report, titled “Considerations for Implementing Measures in Federal Programs” reviews the Clinician Workgroup discussion regarding the measures under consideration for the Merit-Based Incentive Payment System (MIPS) and the Medicare Shared Savings Program. MIPS will consolidate the Physician Quality Reporting System (PQRS), the Value-Modifier (VM) and the Medicare Electronic Health Record (EHR) incentive program into one program that will adjust Medicare payments based on performance. As part of the transition to the consolidated MIPS program, clinician level measures under consideration were proposed by CMS for potential implementation in 2017 and discussed extensively during the Clinician MAP meeting. CMS identified key program needs and priorities for the MIPS program, including outcome measures, measures relevant to specialty providers, domains of person and caregiver experience and outcomes, communication and care coordination and appropriate use and resource use.

#### *Address Challenges Related to Outcome Measures in the Draft Report*

Outcome measures have been identified as a priority, and CMS addressed this priority through the inclusion of twenty-four outcome measures on the MUC list for discussion during the MAP Clinician Workgroup meeting. We support the development of valid and reliable outcome measures that could potentially lead to more direct measures of quality and encourage their development. It is also important to acknowledge that process measures that are evidence-based can be integral to improved outcomes. Outcome measures at the physician level can be particularly challenging when used in quality programs due to small sample sizes, risk adjustment, attribution, and the impact of factors outside of the physician’s control. Holding physicians accountable for factors outside of their direct control would be unfair to physicians and misleading to consumers. **The AAMC recommends that these challenges be acknowledged in the draft report and addressed in the future.**

#### *Appropriate Use and Overuse Measures Should be Based on Solid Evidence*

The MAP expressed an interest in measures of appropriate use or overuse and acknowledged that this remains a gap area and a priority for future development. The report states that many of the MAP members suggested looking at the Choosing Wisely Campaign for guidance and pairing overuse measures with measures of quality for a better understanding of value. AAMC supports the use by physicians of evidence-based clinical support systems to guide their treatment for particular patients. The Choosing Wisely Campaign’s purpose is to promote conversations between patients and their providers around potentially unnecessary tests, treatments, and procedures. The Choosing Wisely guidelines and not intended to be absolute. **We recommend that any measures of overuse based on “Choosing Wisely” guidelines be implemented after the specialty that provides the service have chosen to use the guidelines to create applicable measures that are based on solid evidence, and developed through a process that is inclusive of all specialties that provide the**

**service in question. In the interim, physicians who follow the Choosing Wisely guidelines should be given credit in MIPS under the Clinical Practice Improvement Category.**

### *AAMC Supports Team-Based Care Measures*

AAMC supports the recognition in the draft report of the importance of developing measures of team-based care. Given the complexity of patient care, it is common for multiple clinicians to provide care to the same patient as part of a team with the goal of the best possible care. Each clinician relies upon information and action from other members of the team. A high performing team is an essential tool for a patient centered, coordinated and effective health care delivery system. **In the future, it will be important to measure how a team performs on health care quality, costs, and health outcomes.**

### *Individual Measure Comments*

#### *PQI 91: Prevention Quality Acute Composite and PQI 92: Prevention Quality Chronic Composite*

The MAP draft report references two composite measures under consideration, MUC 15-577 and MUC 15-576 (PQI 91: Prevention Quality Acute Composite and PQI 92: Prevention Quality Chronic Composite, respectively) that were discussed extensively. The AAMC has significant concerns with the use of these measures in the MIPS program and the shared savings ACO program. The Association was pleased to see that the MAP discussed the limitations and potential unintended consequences of these measures, noting the impact that socio-demographic factors may have on the outcomes addressed by these measures, and the fact that these measures were designed for use at the “population level,” not the “clinician level.”

The PQIs were originally designed to measure ambulatory sensitive conditions at a community level and the rate calculated per 100,000 population. Such a large sample size allows communities to evaluate their primary care system at a macro level. These measures were not tested or endorsed by NQF for use at the clinician level, where the population is much smaller. If implemented in the MIPS program, it is possible that physician practices with only 20 attributed patients could be held accountable for performance under this measure. We have major concerns with applying measures that are intended to address overall admission rates at a population level to individual physicians in the MIPS program and to ACOs that have much smaller populations than 100,000.

These measures would also penalize physicians that treat complex patients with multiple chronic conditions given that there is no appropriate clinical risk adjustment. The characteristics of the attributed Medicare beneficiaries can vary widely by physician group practice. Not accounting for the clinical variation in the underlying population is extremely misleading and disproportionately affects the physicians who care for the most complex patients. These measures should have appropriate clinical risk adjustment prior to implementation in any program. In addition, as admissions and readmissions are often connected to the broader community, CMS should consider adding an adjustment or stratification to account for socio-demographic factors.

Despite these challenges with the measure, CMS is currently using these PSI measures under the physician value-based modifier program. In the 2015 Value Modifier Experience Report, groups in the low-quality and/or high-cost categories had worse performance on these measures. These cohorts

tended to have patients with a higher risk score, and therefore this group is unfairly penalized under the current value-based modifier program.

The use of this measure at the ACO level also would have similar challenges with population size and risk adjustment. An ACO patient population is typically much smaller than 100,000. In addition, an ACO is already accountable for costs and has an incentive to reduce admissions and readmissions. Therefore, use of an additional measure involving admissions and readmissions would be duplicative and inappropriate.

We recommend that the issues related to risk adjustment, sociodemographic factors, and attribution be addressed and that these measures be endorsed by NQF prior to implementation in the MIPS program or the shared savings ACO program.

#### *Non-Recommended PSA-Based Screening*

The MAP draft report describes the extensive discussion on measure MUC15-1019, *Non-Recommended PSA-Based Screening*, which is intended to reduce the use of prostate-specific antigen (PSA)-based screening for prostate cancer. This measure was based on a 2012 recommendation from the United States Preventive Services Task Force (USPSTF) that discouraged the use of PSA screening due to a lack of evidence supporting its benefits, giving the service a grade D recommendation. The USPSTF recommendation has been controversial and heavily criticized by the urology community citing concerns for patients.

The AAMC believes that it is premature to establish a quality measure that will eventually be linked to payment based on a recommendation that is involved in widespread medical controversy and for which the standard of care in the community is not clearly established. In addition, the measure is currently being reexamined by USPSTF. We support the MAPs recommendation to wait until the controversy over general PSA screening has been resolved and an evidence-based standard established.

MAP noted that overtreatment in this area is a legitimate concern and that measurement could address more narrow aspects of screening or treatment specifically until the controversy over general PSA screening has been resolved and an evidence-based standard of care is established.

#### *Optimal control of cardiovascular disease (MUC15-275: Ischemic Vascular Disease All or None Outcome Measure (Optimal Control))*

The draft MAP report includes a discussion of the composite measure for optimal control of cardiovascular disease under consideration for the MIPS and MSSP programs. The draft report describes the potential redundancy between this measure and other measures, such as the “Million Hearts” measure currently used in both programs. The MAP supported the value of the composite measure and supported the use of NQF to ultimately decide after thorough review which measure related to quality of cardiovascular care is “best in class” and should be used in the quality programs. We recognize the importance of this composite measure, but once again emphasize the importance of appropriate risk adjustment to account for providers caring for high risk populations from both a clinical and socio-demographic standpoint.

#### *Depression Utilization of the PHQ-9 Tool; Depression Remission at Six Months; Depression Remission at Twelve Months*

The MAP draft plan states that MAP members noted that use of the PHQ-9 tool for depression screening is promoted through measurement in private programs as well as the Adult and Child Core Measure Sets for Medicaid and that fostering alignment across these programs was part of MAP's rationale for supporting a similar measure for MIPS and MSSP. The AAMC recommends that this draft report also reflect the concern raised by some MAP members that this measure have appropriate risk adjustment to account for providers caring for high risk populations from both a clinical and sociodemographic standpoint. For these high risk populations it could be very difficult to achieve a PHQ score of greater than 5 at 6 months or 12 months (remission) as described in the measure. There may be other measures related to depression that may be more appropriate to use in the MIPS program.

***CMS Should Ensure that Publicly Reported Data is Valid, Reliable, Accurate, and Meaningful***

CMS has continued to expand clinical quality information that is publicly reported on its Physician Compare website. CMS intends to continue public reporting of performance results through the Physician Compare website based on measures in the MIPS program through either the clinician web page or through a downloadable spreadsheet. The Clinician MAP workgroup provided input regarding which measures would be appropriate to publicly report on the clinician web page under the MIPS program.

The AAMC recommends that in the initial years of the MIPS program, CMS include data indicating whether an EP satisfied the reporting requirements for the quality measure. However, calculating and displaying performance data on the public website in the early years of the program would be premature. There are too many challenges with measures related to risk adjustment, attribution, sociodemographic factors to publicly report performance data at this early stage. CMS should only report measures that are valid, reliable, and accurate, and are meaningful to consumers and providers.

**MAP Hospital Workgroup Comments**

***Accountability Measures Must Be Adjusted for Sociodemographic Status (SDS)***

The AAMC has long advocated for appropriate adjustment for sociodemographic status (SDS) factors for certain outcome measures. The AAMC agrees with the Workgroup's preliminary recommendations that the pneumonia episode-of-care payment and excess days in acute care after hospitalization measures should undergo review in the SDS trial period to determine whether there is a conceptual and empirical relationship between outcomes and SDS factors prior to inclusion in the IQR program. The Association also strongly believes that other approved Hospital MAP Workgroup measures, including hospital visits within 7 days after hospital outpatient surgery and CABG mortality, should be submitted for review in the SDS trial period.

The AAMC strongly supports a robust and transparent SDS trial period. The Association is very concerned that the issues and concerns regarding SDS raised by relevant steering committees, who are tasked with reviewing these measures, are not being sufficiently addressed. We ask that the SDS trial period be a priority for the MAP, NQF, and CMS in 2016. The AAMC also notes that there are several measures in the current performance programs which have not been SDS adjusted. We ask that MAP include a recommendation regarding the need to adjust the existing measures, and have the

opportunity to review all measures for appropriateness in the performance programs after the SDS trial period has concluded.

### ***All Measures Reviewed by the MAP Hospital Workgroup Should be NQF Endorsed***

NQF endorsement demonstrates that a measure has been tested, is reliable, and can be used in a specific setting. With the volume of measures the MAP has to review, the Workgroups and Coordinating Committee rely heavily on NQF endorsement to ensure the measure is sound. Since hospital measures are typically not re-reviewed by the Workgroup, it is essential that these measures be NQF-endorsed at the time of consideration so that members are fully informed as to the measure's appropriateness for the Medicare reporting and performance programs.

### ***Hospital Performance Program Measures Should be Publicly Reported Prior to MAP Review***

In this year's MUC list, CMS included new or revised measures for possible inclusion in Medicare hospital quality performance programs. The AAMC remains concerned that several of the measures brought forward for Workgroup review had not been publicly reported, which limits the public's ability to provide feedback. Publicly reporting measures in the IQR Program allows MAP Workgroup stakeholders to be fully informed regarding any complications in submitting the measures, and allows time to identify errors, unintended consequences, or other concerns with the measure's methodology.

### ***Individual Measure Review***

#### ***Patient Safety and Adverse Events Composite (PSI-90)***

The Hospital MAP Workgroup supported a revised patient safety and adverse events composite measure (PSI-90) for future inclusion in the IQR and HACRP programs. As of December 2015, the revised composite measure had not been formally reviewed by the NQF Board of Directors. While the AAMC appreciates that the PSI-90 measure has undergone initial improvements, we continue to have serious concerns with the underlying structure of this composite measure.

As noted by Hospital MAP Workgroup members, the Medicare Payment Advisory Commission (MedPAC)<sup>1</sup>, and other academic researchers<sup>2</sup>, the measure components contain serious deficiencies: they may not be preventable through evidence based practices, lack the statistical reliability of the Centers for Disease Control (CDC) National Healthcare Safety Network (NHSN) measures, are susceptible to surveillance bias, and are based on administrative claims data and therefore cannot capture the full scope of patient-level risk factors. In addition, teaching hospitals are more likely to be penalized by this measure because they treat a more complex and vulnerable patient population. Since PSI-90 components focus on surgical issues, teaching hospitals are more likely to be disproportionately impacted by this measure because they tend to have a larger volume of surgeries.<sup>3</sup>

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<sup>1</sup> "MedPAC Comments on FY 2014 IPPS Proposed Rule." June 25, 2013. Retrieved from: <http://www.medpac.gov/documents/comment-letters/medpac-s-comment-on-cms-s-acute-and-long-term-care-hospitals-proposed-rule.pdf?sfvrsn=0>

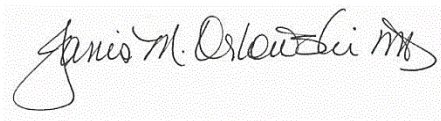
<sup>2</sup> Rajaram, Ravi et al. *Concerns About Using the Patient Safety Indicator-90 Composite in Pay-for-Performance Programs*. *JAMA*. Vol 313, No. 9. March 3, 2015. Retrieved from: <http://jama.jamanetwork.com/article.aspx?articleid=2109967>

<sup>3</sup> "Medicare's Hospital-Acquired Condition Reduction Program. Health Affairs: Health Policy Briefs. August 6, 2015. Retrieved from [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=142](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=142)

For all of the reasons noted above, the AAMC strongly supports the removal of the PSI-90 composite from both the HACRP and VBP programs. The Association remains unconvinced that the updates to the PSI components and weights are sufficient to address these considerable measure deficiencies. Until a revised PSI measure has been shown to meet an acceptable level of validity, is actionable, and has been sufficiently publicly reported, it should not be considered for inclusion in a Medicare performance program.

Thank you for consideration of these comments. For questions regarding the Clinician MAP comments, please contact Gayle Lee ([galee@aamc.org](mailto:galee@aamc.org), 202-741-6429), and for questions regarding the Hospital MAP comments, please contact Scott Wetzel ([swetzel@aamc.org](mailto:swetzel@aamc.org), 202-828-0495).

Sincerely,

A handwritten signature in black ink that reads "Janis M. Orlowski M.D.". The signature is written in a cursive style and is positioned above a light gray rectangular background.

Janis M. Orlowski, M.D., M.A.C.P.  
Chief Health Care Officer

cc: Kate Goodrich, CMS  
Scott Wetzel, AAMC  
Gayle Lee, AAMC