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January 10, 2019

Charles Kahn, III, MPH
Bruce Hall, MD, PhD
Co-Chairs, Measure Applications Partnership Coordinating Committee
C/O National Quality Forum
1030 15th St NW, Suite 800
Washington, DC 20005

RE: January 2019 Measure Applications Partnership Pre-Rulemaking Draft Report

Dear Mr. Kahn and Dr. Hall:

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 2019 Considerations for Implementing Measures in Federal Programs draft report. The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 152 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

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 MAP recommendations for both hospitals and clinicians:

- Regarding the clinician measures under consideration, the AAMC strongly believes that providers should not be held accountable for activities outside their control. The 11 episode level cost measures must be appropriately risk adjusted, including for social risk factors, and the attribution methodology for episodes should clearly and accurately determine the relationship between patient and clinician before such episode-level cost measures are incorporated into the Quality Payment Program. The 2 re-evaluated total cost measures (Medicare Spending per Beneficiary (MSPB) and Total Per Capita Cost) must similarly be appropriately adjusted for both clinical and social risk factors before the measures are incorporated into the Quality Payment Program.

- For the hospital measures, the AAMC continues to strongly believe 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. Additionally, the AAMC recommends that the report appropriately distinguish the Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals (Promoting Interoperability Program) as separate from the IQR. While electronic clinical quality measures are shared between the two programs, the programs have unique histories and different penalties on hospitals for failure to meet a given program's distinct requirements and the report should appropriately reflect that.

MAP Clinician Workgroup Comments

Cost Measures Should be Appropriately Risk-Adjusted and the Attribution Methodology Should be Clear and Accurately Determine Patient/Clinician Relationship

Cost measures have been identified as a priority, and CMS addressed this priority through the inclusion of 13 cost measures for the MIPS program on the MUC list for discussion during the MAP Clinician Workgroup meeting. The AAMC remains concerned that none of the 13 cost measures are adjusted to account for socio-demographic status (SDS). In addition to patient clinical complexity, SDS factors can drive differences in average costs. In particular, physicians at academic medical centers (AMCs) care for vulnerable populations of patients who are sicker, poorer, and more complex than patients treated elsewhere.

In regard to attribution – AAMC has previously commented that attribution methods used should be clear and transparent to clinicians and that it is critical that there be an accurate determination of the relationship between a patient and a clinician to ensure that the correct clinician is held responsible for the patient's outcomes and costs. Attribution is complicated, given that most patients receive care from numerous clinicians across several facilities, and AAMC has urged CMS to explore better data sources and analytic techniques to support more accurate attribution. In addition, the movement in medicine has been to team-based care. The MAP, through its recommendations, and CMS should be careful not to incent patterns of care that are outdated. **The AAMC recommends that: (1) cost measures include risk-adjustment for SDS factors, (2) the attribution methodology is transparent, and (3) the appropriate clinician is held responsible for the patient's outcomes and costs.**

Individual Measure Comments

Total Per Capita Cost Measure

The AAMC has concerns with the use of the total per capita cost measure in the MIPS program. The total per capita cost measure is a global measure of all Part A and Part B resources used during the performance period. The measure itself would be inclusive of a number of the episode condition measures that are also included in the MIPS program. It is duplicative to assess performance in the cost performance category on both the per capita cost measures and episode condition measures.

CMS recently changed the attribution methodology and conducted field testing on the revised total per capita cost measure. At this time, information on the validity of the revised attribution methodology is not available. Without this information, it is challenging to assess the validity of this measure. Given these concerns, the MAP should question whether it is appropriate to include this measure in the MIPS program in the future.

Medicare Spending Per Beneficiary Clinician Measure

The AAMC has concerns with the use of the total per capita cost measure in the MIPS program. Many of the same beneficiaries captured in the episode-based cost measures will also be included in the MSPB measure and therefore it is duplicative to assess performance on both these measures. CMS recently changed the attribution methodology and conducted field testing on the revised MSPB measure. At this time, information on the validity of the revised attribution methodology is not available.

MAP Hospital Workgroup Comments

Distinguish Differences Between Programs in the Draft Report

The draft report for hospitals currently describes the IQR and Promoting Interoperability Programs as a single or joint program, which may mislead readers less familiar with these programs. The AAMC recommends that the two programs be described separately to better document their separate and unique histories and requirements for hospitals. An alternative would be to retain the joint write up acknowledging the programs' similar goals and shared measures, and separately detail the incentive structures for each program. The AAMC believes it is important that the report note that the Promoting Interoperability Program has a separate 75 percent reduction of the annual payment update for hospitals that do not participate in or fail to meet the program's requirements. As currently drafted, the report only describes the structure of the incentives for the IQR Program.

Individual Measure Review

Cesarean Birth (CB)

The Hospital MAP did not support, with potential for mitigation, the Cesarean Birth (MUC18-52) electronic clinical quality measure (eCQM) for rulemaking. While the AAMC agrees with the importance of eliminating early deliveries and improving maternal health outcomes, we do not support this measure as currently specified and agree with MAP's recommendation. The draft report accurately summarizes the MAP's discussion, including concerns about the failure to exclude high-risk conditions such as pre-eclampsia/eclampsia from the measurement population and potential unintended consequences of increased maternal mortality in states that use the chart-abstracted version of the measure. The MAP also discussed concerns with the data collection process for this measure, cautioning that inclusion of a measure before the data collection process is ready may have the unintended consequence of stalling the improvement of data quality.

Hospital Harm – Pressure Injury

The Hospital MAP conditionally supported the pressure injury eCQM (MUC18-107) pending review and endorsement once the measure is fully tested. The AAMC believes that pressure injuries are important to measure and can reduce patient harm, and agrees with the MAP that the measure should be vetted further before its inclusion in Medicare quality reporting programs. Specifically, CMS should complete testing and submit the measure for NQF endorsement, with a recommendation that the NQF Disparities Committee review and provide input on adjusting for social risk factors. The AAMC is concerned that implementation of the measure without appropriate risk adjustment is likely

to disproportionately impact academic medical centers and safety net providers who treat more complex patients. The AAMC agrees with the MAP's suggestion that the measure exclude patients with certain conditions or undergoing certain types of treatments that may not be appropriate to receive the evidence-based pressure injury reducing interventions (e.g., extracorporeal membrane oxygenation [ECMO]).

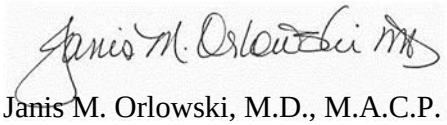
Hospital Harm- Hypoglycemia

The Hospital MAP conditionally supported the hypoglycemia eCQM (MUC18-109) pending review and re-endorsement once the measure is fully tested. The AAMC agrees that measurement of hypoglycemic events is important to prevent avoidable harm from use of antihyperglycemic medications, and that the revised measure should be re-endorsed prior to inclusion in future rulemaking. The AAMC's concerns with the revised measure include consideration of appropriate risk adjustment. Process measures do not generally need risk adjustment, but in the case of glucose monitoring it is important to note that some procedures may warrant exclusion due to glucose measurement swings outside of the hospital's control (e.g., coronary artery bypass surgery [CABG] and sepsis) and should be measured separately from broader hospital measurement. The AAMC also questions the use of lab testing to measure glucose levels rather than point of care testing using blood glucose monitors and asks that the measure developer more clearly denote that point of care testing is included in measurement. We also support the MAP's recommendation to monitor the potential impact of the recent guidance from the FDA that could impact the tools available to hospitals for blood glucose monitoring and thus implementation of the measure.

Conclusion

Thank you for consideration of these comments. For questions regarding the Clinician MAP comments, please contact Gayle Lee (galee@aamc.org, 202-741-6429), and for questions regarding the Hospital MAP comments, please contact Phoebe Ramsey (pramsey@aamc.org, 202-448-6636).

Sincerely,



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Chief Health Care Officer

cc: Gayle Lee, AAMC
Phoebe Ramsey, AAMC