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Charles Kahn, III, MPH
Misty Roberts, MSN
Co-Chairs, Measure Applications Partnership Coordinating Committee
c/o National Quality Forum
1099 14th St NW, Suite 500
Washington, DC 20005

RE: Measure Applications Partnership 2020-21 Initial Measure Recommendations

Dear Mr. Kahn and Ms. Roberts:

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the National Quality Forum (NQF) Measure Applications Partnership's (MAP's) 2020-21 initial measure recommendations for the Centers for Medicare & Medicaid Services' (CMS) measures under consideration (MUC). The AAMC is a not-for-profit association dedicated to transforming health through medical education, patient care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and their more than 179,000 full-time faculty members, 92,000 medical students, 140,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The following are the AAMC's high-level comments on the MAP recommendations for both hospitals and clinicians:

- For all measures, the AAMC continues to strongly believe that measures included on the MUC list be fully specified and NQF-endorsed *prior* to MAP review.
- Additionally, the AAMC is steadfast in our belief that that providers should not be held accountable for activities outside their control. Measures must be valid and reliable at the hospital, clinician, or practice group level, including appropriate attribution of outcomes or episode-based total costs of care to a single clinician or practice. Additionally, the AAMC believes that certain quality measures (particularly outcome and cost measures) must be adjusted for social risk factors (SRFs) prior to inclusion in the public reporting and performance programs.

MAP Hospital Workgroup Comments

SARS-CoV-2 Vaccination Coverage among Healthcare Personnel

The Hospital MAP did not support the COVID-19 vaccination process measure (MUC2020-0044), with potential for mitigation. The three areas for mitigation are that prior to implementation the evidence should be well documented, and that the measure specifications should be finalized, followed by testing and NQF endorsement. The AAMC supports the efforts to advance measurement in response to the national pandemic but does not support inclusion of a measure that has not been fully specified and is currently under

development. Furthermore, the AAMC is concerned that this measure is premature when no vaccine is fully approved (beyond an emergency use authorization) by the Food and Drug Administration (FDA) nor is widely available. **The AAMC agrees with the MAP's recommendation.**

Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)

The Hospital MAP supported the Total Hip/Knee Arthroplasty patient-reported outcomes (PRO) measure (MUC2020-003) for future rulemaking. While the AAMC wholeheartedly supports the movement towards patient-centered approaches to quality measurement, we believe that there is need for more evaluation of the survey fatigue on patients and the interaction of the measure's survey instrument with the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The CAHPS survey has seen declining response rates over the past several years, and it begs the question whether incorporating another survey-based measure into federal quality programs could further erode such response. There was some discussion by the Hospital MAP of whether it is feasible to examine response rates across the two patient survey measures to assess such fatigue. **The AAMC recommends that the MAP recommendation be conditional support for rulemaking based on evaluation of the measure's interaction and impact on CAHPS.**

Global Malnutrition Composite Score

The Hospital MAP conditionally supported for rulemaking the malnutrition electronic clinical quality measure (eCQM) composite (MUC2020-0032) pending NQF endorsement. The AAMC agrees that malnutrition is a critical clinical quality area not directly addressed by measures in the Hospital Inpatient Quality Reporting (IQR) Program, and that there is value in identifying and treating malnutrition upon admission to the hospital. We believe that NQF endorsement of the measure is critical and should be completed before the measure is proposed for addition to the IQR. **The AAMC agrees with the MAP's recommendation.**

Appropriate Treatment for ST-Elevation Myocardial Infarction (STEMI) Patients in the Emergency Department (ED)

The Hospital MAP conditionally supported for rulemaking the appropriate treatment for STEMI patients process measure (MUC2020-0004) pending NQF endorsement. In general, the AAMC believes that quality measurement should move towards outcomes-based measurement. However, we acknowledge the value of process measures to improve adherence to clinical practice recommendations as an important step towards outcomes-based measurement. We agree with the MAP that the NQF-endorsement evaluation will ensure necessary electronic health record feasibility, reliability, and validity testing necessary before the measure is introduced in the OQR. **The AAMC agrees with the MAP's recommendation.**

Breast Screening Recall Rates

The Hospital MAP conditionally supported for rulemaking the breast screening recall rate outcomes measure (MUC2020-0005) pending NQF endorsement. The AAMC agrees that it is critical to ensure that abnormal screenings receive appropriate follow-up. We believe that the NQF-endorsement process will evaluate the appropriateness of this measure's basis on clinical consensus recall rates rather than specific clinical guidelines, in addition to reviewing reliability and validity of the measure. **The AAMC agrees with the MAP's recommendation.**

MAP Clinician Workgroup Comments

SARS-CoV-2 Vaccination by Clinicians

The Clinician MAP did not support the COVID-19 vaccination process measure (MUC2020-0045), with potential for mitigation. The three areas for mitigation are that prior to implementation the evidence should be well documented, and that the measure specifications should be finalized, followed by testing and NQF endorsement. The AAMC supports the efforts to advance measurement in response to the national pandemic but does not support inclusion of a measure that has not been fully specified and is currently under development. Furthermore, the AAMC is concerned that this measure is premature when no vaccine is fully approved (beyond an emergency use authorization) by the FDA nor is widely available. **The AAMC agrees with the MAP's recommendation.**

Episode-based Cost Measures

The Clinician MAP conditionally supported two of the episode-based costs measures (*Colon and Rectal Resection* [MUC2020-0016] and *Melanoma Resection* [MUC2020-0018]) for future rulemaking for the Merit-based Incentive Payment System (MIPS) program subject to NQF endorsement. The Clinician MAP did not support the other three episode-based costs measures (*Asthma/Chronic Obstructive Pulmonary Disease* [MUC20-0015], *Diabetes* [MUC2020-0017], and *Sepsis* [MUC2020-0019]) for future rulemaking for the MIPS program with potential for mitigation. Mitigation for the three measures focused on evaluation of the actionability and connection between upstream medical interventions and downstream costs, in addition to NQF endorsement. The AAMC agrees with concerns about episode-based cost measures relying on the suggestion that providing certain upstream preventions will result in lower costs of care, and that lower costs will result in better patient outcomes. Furthermore, the AAMC remains concerned that none of the 13 cost measures are adjusted to account for social risk factors (SRFs). In addition to patient clinical complexity, SRFs 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, further complicating appropriate attribution to a single clinician. The MAP, through its recommendations, and CMS should be careful not to incent patterns of care that are outdated. **The AAMC recommends that the MAP recommendation be "do not support with potential for mitigation" for each of the episode-based cost measures.**

ACO-Level Days at Home for Patients with Complex, Chronic Conditions

The Clinician MAP conditionally supported the days at home measure (MUC2020-0033) for future rulemaking for the Medicare Shared Savings Program (MSSP) pending NQF endorsement. CMS recently finalized a change to MSSP ACO quality reporting policies to align it with other MIPS APMs under the new APM Performance Pathway (APP). Part of the rational for this change was comparability of quality across

APMs, with a benefit of reducing the number of measures ACOs must report on under the new APP. The AAMC is unclear on the intent of the APP if CMS is also contemplating adding further MSSP-ACO specific measures on top of the APP measure set that are not more broadly aligned with MIPS APMs. Furthermore, two of the six measures under the APP are admission-related measures, and this measure is similarly based around inpatient utilization. The financial structure of the MSSP generally incentivizes reducing unnecessary acute and emergent care utilization. Thus, this measure duplicates the incentive/penalty structures in the MSSP payment model.

Finally, the measure has not been submitted for NQF endorsement, rendering it premature for consideration for inclusion in the MSSP. Due to these concerns, **the AAMC recommends that the MAP recommendation be downgraded to "do not support with the potential for mitigation."**

Conclusion

Thank you for consideration of these comments. For questions regarding the AAMC's comments, please contact Phoebe Ramsey (pramsey@aamc.org, 202-448-6636).

Sincerely,

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Chief Health Care Officer

cc: Gayle Lee, AAMC
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