Association of
American Medical Colleges
655 K Street, NW, Suite 100, Washington, DC 20001-2399
T 202 828 0400
aamc.org

Via electronic submission: https://acumen.qualtrics.com/jfe/form/SV_bI1XfyMnL5VsVoy

May 28, 2022

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Re: MIPS Episode-Based Cost Measure Comprehensive Reevaluation

Dear Administrator Brooks-LaSure:

AAMC (The Association of American Medical Colleges) thanks the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the Episode-Based Cost Measure Comprehensive Reevaluation. The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members comprise all 155 accredited U.S. and 16 accredited Canadian medical schools; approximately 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 the millions of individuals employed across academic medicine, including more than 191,000 full-time faculty members, 95,000 medical students, 149,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. In 2022, the Association of Academic Health Centers and the Association of Academic Health Centers International merged into the AAMC, broadening the AAMC's U.S. membership and expanding its reach to international academic health centers. Learn more at aamc.org.

The AAMC appreciates CMS's dedication to revaluating and updating the eight cost measures listed below added to the Merit Incentive Payment System (MIPS) in performance year 2019, to ensure the measures accurately reflect the cost of patient care:

- Elective Outpatient Percutaneous Coronary Intervention (PCI)
- Intracranial Hemorrhage or Cerebral Infarction
- Knee Arthroplasty
- Simple Pneumonia with Hospitalization
- ST-Elevation Myocardial Infarction (STEMI) with PCI
- Screening/Surveillance Colonoscopy
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia

- Routine Cataract Removal with Intraocular Lens Implantation

Cost Measures Should Include Appropriate Risk Adjustment for Social Risk Factors

These eight episode cost measures are risk-adjusted by demographic variables, such as age, and comorbidities by using Hierarchical Condition Categories (HCC) data, and other clinical characteristics. Of special concern is that none of the cost measures are adjusted to account for health-related social risk factors. In addition to differences in patient clinical complexity, health-related social needs can drive differences in average episode costs.

The National Academies of Science, Engineering and Medicine and the HHS Assistant Secretary for Planning and Evaluation have clearly acknowledged that social risk factors such as housing instability, low income, and health literacy may explain adverse outcomes and higher costs. Without accounting for these factors, the scores of physicians that treat patients with health-related social needs will be negatively and unfairly impacted and their performance will not be accurately reflected by their score. Physicians at academic medical centers (AMCs) often care for patients from under resourced and underinvested communities who are sicker, poorer, and have more complex medical needs than many patients treated elsewhere. **We request that these measures be adjusted to account for these risk factors.**

Attribution Method Should be Clear and Transparent and Correctly Capture the Patient/Clinician Relationship

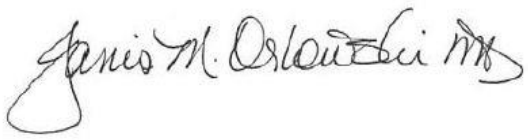
For cost measures it is critical that there be an accurate determination of the relationship between a patient and a clinician to ensure that clinicians are appropriately held responsible for their patient's outcomes and costs. This is complicated given that many patients receive care from numerous clinicians, and maybe across several facilities. Furthermore, academic medical centers and other providers have moved towards team-based care. Team-based care allows clinicians to work as a multispecialty team partnering with their patients and patient families to address medical conditions and provide comprehensive care. CMS should ensure that the attribution process encourages team-based care rather than incentivizes siloed care.

AAMC has previously urged CMS to explore better data sources and analytic techniques to support more accurate attribution.[1, 2] Attribution methods should be clear, transparent, and easily understood by clinicians. **The AAMC recommends CMS establish a more clear and transparent attribution methodology to ensure the appropriate clinician is held responsible for the patient's outcomes and costs.**

The AAMC appreciates your consideration of the above comments. Should you have any questions, please contact Gayle Lee at galee@aamc.org or Ki Stewart at kstewart@aamc.org

[1] *See* AAMC Comments on the CY2019 Medicare Physician Fee Schedule and Quality Payment Program, at page 32 (September 2018).
[2] *See* AAMC Comments on the CY2020 Medicare Physician Fee Schedule and Quality Payment Program, at page 22 (September 2019).

Sincerely,



Janis M. Orlowski, MD, MACP
Chief Health Care Officer
AAMC

Cc: David Skorton, MD, President and CEO, AAMC
Gayle Lee, AAMC
Ki Stewart, AAMC