



Association of
American Medical Colleges
655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399
T 202 828 0400 F 202 828 1125
www.aamc.org

January 8, 2020

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: Measure Applications Partnership 2020 Considerations for Implementing Measures in Federal Programs 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's (MAP's) 2020 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, and is itself an NQF member. Our members are all 154 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. Together, these institutions and individuals are the American academic medicine community.

The AAMC appreciates the MAP Workgroups' thoughtful review and discussion of the measures under consideration (MUC) as part of the Centers for Medicare & Medicaid Services' (CMS) pre-rulemaking process for implementing new quality measures in its federal healthcare programs. The following are the AAMC's high-level comments on the MAP recommendations for both hospitals and clinicians:

- 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 and be NQF-endorsed *prior* to MAP review. 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 Hospital Inpatient Quality Reporting Program (IQR). While electronic clinical quality measures are shared between the two programs, the programs have unique histories and distinct penalties on hospitals for failure to meet a given program's reporting requirements and the report should appropriately reflect that.
- Regarding the clinician measures under consideration, the AAMC strongly believes that providers should not be held accountable for activities outside their control. Measures must be valid and reliable at the

clinician or practice group level, including appropriate attribution of outcomes to a single clinician or practice. Similar to hospital measures, the AAMC believes that certain quality measures (particularly outcome and cost measures) must be adjusted for SDS prior to inclusion in the programs.

MAP Hospital Workgroup Comments

Differentiate Between Hospital Reporting Programs in the Draft Report

The draft report for hospitals currently describes the IQR and Promoting Interoperability Programs as a single program, which may mislead readers less familiar with these programs. The AAMC recommends that the two programs be described separately to better document their unique histories and requirements for hospitals. An alternative would be to retain the joint write up acknowledging the programs' similar goals and shared electronic clinical quality measures (eCQMs), 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 (a 25 percent reduction of the annual payment update) for the IQR Program.

Individual Measure Comments

Maternal Morbidity: Concerns With Process

The Hospital MAP did not support, with potential for mitigation, the Maternal Morbidity structural measure (MUC2019-114) for future rulemaking. While the AAMC wholeheartedly agrees that there is a pressing need to address maternal morbidity rates in the United States, **we do not support this measure as initially specified and agree with MAP's recommendation.** However, we have concerns with the draft report's summary of the measure's specific attestation statement and the MAP's subsequent discussion. CMS initially provided the NQF with the specified attestation statement for the measure under consideration, since it is a structural measure. Then, to kick off the MAP's discussion at the in-person meeting, CMS asked to present *modified* attestation language, which is used in the draft report.

While this modified attestation was in fact the measure specification discussed by the MAP, the AAMC has significant concerns with this overall process. We believe that the MAP should evaluate the measure *as delivered in advance* as part of the pre-rulemaking process, rather than evaluate a revised measure that was not shared until the day of the hospital MAP meeting. Stakeholders who provided comments in advance to the MAP did so in good faith that they were reviewing the measure to be considered by the MAP, and not a measure subject to revision. Furthermore, the measure revision and process created a significant amount of discussion and confusion, including whether the MAP workgroup's preference for further revised language met the MAP's standards for "potential for mitigation." The draft report should accurately describe this process to mitigate similar day-of measure revision issues in the future.

Hospital Harm- Severe Hyperglycemia: Agree with MAP's Recommendation

The Hospital MAP conditionally supported for rulemaking the hyperglycemia eCQM (MUC2019-26) pending NQF endorsement. The AAMC agrees that hospitals should implement protocols to manage hyperglycemia for critically ill patients. However, we are concerned that the measure's incorporation in a federal program may cause the unintended consequence of overutilization of antihyperglycemic agents and lead to increases in hypoglycemia, which is much more serious harm. The measure developer should ensure that the measure incentives care workflows include appropriate glucose monitoring and proper glycaemic

management for all patients. We also agree with the Rural Health Workgroup’s concern regarding measurement derived from point-of-care testing, which may not be incorporated into the electronic health records (EHR) systems in all hospitals and may make it difficult to compute the measure. The measure must be NQF-endorsed and demonstrate reliability and validity. **The AAMC agrees with the MAP’s recommendation.**

MAP Clinician Workgroup Comments

Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Eligible Clinician Groups: Revise Recommendation

The Clinician MAP conditionally supported the all-cause readmissions measure (MUC2019-27) for future rulemaking for the MIPS program pending NQF endorsement. The AAMC is concerned that the measure’s description does not provide great detail on the measure’s clinical risk adjustment or whether the measure accounts for socio-demographic risk factors. Readmissions are often connected to the broader community in which the patient lives and access to care, and CMS should consider adding an adjustment or stratification to account for socio-demographic factors, as is done in the Hospital Readmission Reduction Program. Additionally, in regard to patient attribution, the AAMC is concerned that during the endorsement process for this measure, the measure developer was unable to provide support for attribution of the measure to up to three physicians or practices. Finally, NQF endorsement is critical to establishing that the measure has been appropriately tested and is proven valid and reliable. We recommend that the issues related to risk adjustment, accounting for sociodemographic factors, attribution, and measure reliability be addressed. **The AAMC recommends that the MAP recommendation be revised to “do not support with potential for mitigation.”**

Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate: Downgrade Recommendation

The Clinician MAP conditionally supported the catheter rate measure (MUC2019-66) for future rulemaking for the MIPS program pending NQF endorsement. The AAMC understand that access to non-catheter use is preferable, but it may not be available in all cases. Late referrals to dialysis or patients with poor vascular health (or vessels) clinically limit care to long-term catheterization, and the measure must account for this clinical complexity. We echo the workgroup’s concerns with the measure’s reliability and encourage the measure developer to conduct rigorous testing. During public comment on the measure and its testing during NQF endorsement review in 2018, stakeholders identified concerns with the reliability and validity of the measure as specified and the belief that additional testing must be conducted to further improve the measure prior to implementation. Due to these concerns, **the AAMC recommends that the MAP recommendation be downgraded to “do not support with the potential for mitigation.”**

MIPS Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions: Do Not Support

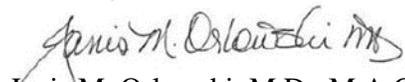
The Clinician MAP did not support the hospital admission rates measure (MUC2019-37) for future rulemaking for the MIPS program, but *did* conditionally support the measure for the Medicare Shared Savings Program (SSP), pending NQF endorsement. The AAMC recognizes the need to improve the care of patients with multiple chronic conditions but has significant concerns with the use of these measures in either of these programs. Attribution of this measure to individual clinicians or clinician groups is of great concern

in regard to the MIPS Program. We do not believe that sufficient evidence was provided to support the theory that physicians or practices, in the absence of some coordinated program or payment offset (e.g., care management fee), can implement structures or processes that can lead to improved performance on this measure. The characteristics of the 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. In regard to the SSP, the AAMC believes that this measure is duplicative and inappropriate because the accountable care organization (ACO) is already accountable for costs and has an incentive to reduce admissions and readmissions. Total-cost-of-care financial risk under the ACO should free physicians to make determinations about clinically appropriate sites of care, including hospital admission, and be measured on the clinical outcome of care. We recommend that the issues related to risk adjustment, sociodemographic factors, and attribution be addressed and that the measure be endorsed by NQF prior to implementation in the MIPS program or the SSP. NQF endorsement is critical to establishing that the measure has been appropriately tested and is proven valid and reliable. In light of these concerns, **the AAMC recommends that the MAP recommendation be “do not support” for both programs.**

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,



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

cc: Gayle Lee, AAMC
Phoebe Ramsey, AAMC