



**Association of
American Medical Colleges**
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Karen Milgate
Director of the Office of Policy
Centers for Medicare and Medicaid Services
Mail Stop C4-03-04
7500 Security Boulevard
Baltimore, MD 21244-1850

Via e-mail: physicianvbp@cms.hhs.gov

Dear Ms. Milgate,

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on defining episode logic for the Medicare physician resource use measurement program. The AAMC is a not-for-profit association representing all 131 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians.

The Centers for Medicare and Medicaid Services (CMS) has been researching different methods to measure efficient delivery of care. "Episodes of care" is one option that allows for the comparison of resources based on clinically similar conditions. CMS included both per-capita and episodes of care measures in its pilot program to provide physicians with confidential feedback on their resource use. The episodes for the pilot program were generated using two commercially available proprietary products, but these tools did not focus on the complexities of the Medicare population. CMS will be releasing a request for proposal (RFP) asking interested applicants to develop a transparent, publicly available grouper logic and software specific to the Medicare population. The agency is soliciting comments on methodology considerations and other policy issues. To facilitate this process, CMS posted a background paper and hosted a listening session on November 10, 2009. CMS posed several thoughtful questions regarding the clinical logic for episode groupers, including how to measure patients with multiple comorbidities and how to effectively risk-adjust episodes of care.

The AAMC recognizes that there are variations in care and resource use. While we support efforts to better understand the underlying reasons for variation, we oppose changing payment policy until both the drivers of variation and any unintended consequences are better understood. Factors such as poverty and severity of illness could affect the amount of resources needed to provide quality patient care. Recent peer-reviewed data for a group of six California hospitals

demonstrated that increased utilization of resources is associated with decreased mortality.¹ To better understand the factors that contribute to variations, the AAMC is coordinating an initiative with AAMC member hospitals to identify the sources and drivers of variations in resource utilization and to implement quality improvement initiatives intended to reduce or eliminate unnecessary variations without negatively affecting quality. These and similar efforts are needed to ensure that there is an understanding of the consequences before policy changes are adopted.

While the AAMC has not conducted specific analyses with data from episode groupers, we partnered with the University HealthSystem Consortium to analyze readmission rates at 100 academic medical centers. Because hospitalizations are often the primary driver of costs in episodes of care, we believe the following results are particularly relevant to episode measurement:

- There was an association between readmission rates and income. Patients living in zip codes where the median salary was in the lowest quartile had higher readmission rates than those with median incomes in the top quartile (18.9% for incomes less than or equal to \$22,500 compared to 16.3% for incomes greater than \$46,000).
- Patients with an initial MS-DRG for psychosis had the highest volume of Medicare readmissions, representing 2.6% of all readmissions. This finding is consistent with anecdotal information from our members that managing resources for patients with mental health and substance abuse disorders is particularly challenging.

The AAMC suggests that the RFP address these and similar issues to ensure that the contracted deliverable does not unduly affect vulnerable patients and the providers who treat them. In particular, the AAMC urges CMS to include socio-economic data in the risk adjustment methodology. Additionally, episodes of care involving patients who have substance abuse and mental health comorbidities should either be removed or put into a separate category.

CMS has indicated that it would like to build on the existing knowledge of episode groupers. The AAMC agrees with this approach and encourages CMS to include in its RFP a requirement that the contractor must consult with organizations that have worked on cost-of-care measures. In particular, the contractor should incorporate, where possible, clinical logic that has been publicly reviewed and agreed upon by physicians and other stakeholders. The AAMC also supports incorporating clinically-enriched data, such as lab results or cancer stage information, where possible, in the episode and risk-adjustment logic.

In addition to soliciting comments on the logic used to define episodes, CMS asked for comments on policy issues which could affect the testing and use of episodes. Regarding two of the policy issues – attribution and benchmarking – the AAMC suggests that the methodology take into account the multiple missions of academic clinical faculty who provide patient care while simultaneously training medical students, residents and other healthcare professionals, as

¹ Ong, M etal. “Looking Forward, Looking Back: Assessing Variations in Hospital Resource Use and Outcomes for Elderly Patients With Heart Failure”. *Circulation: Cardiovascular Quality and Outcomes*. 2009 Published online before print October 13, 2009. doi: 10.1161/CIRCOUTCOMES.108.825612

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well as conducting research. Faculty physicians provide specialized services and treat complex referral patients. An AAMC analysis of Medicare hospitalizations showed that teaching hospitals cared for seventy-two percent of all Medicare patient transfers and that the median case mix index for all patients, both transfers and others, was higher at teaching hospitals than at non-teaching hospitals.² CMS should not adopt a system that will penalize faculty physicians for treating complex patients, engaging in clinical research, and for teaching residents and other learners.

Thank for your consideration of the above comments. If you have any questions, or require further information, please contact Mary Patton at 202-862-6297 or mpatton@aamc.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Conroy', with a stylized flourish at the end.

Joanne Conroy, M.D.
Chief Health Care Officer

cc: Mary Patton

² AAMC Analysis in Brief: Hospital Transfers of Medicare Patients. February 2009.
http://www.aamc.org/data/aib/aibissues/aibvol9_no1.pdf