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January 13, 2015

George Isham, M.D.
Elizabeth McGlynn, Ph.D.
Co-Chairs, Measure Applications Partnership
C/O National Quality Forum
1030 15th St NW, Suite 800
Washington, DC 20005

RE: January 2015 Measure Applications Partnership Pre-Rulemaking Draft Report

Dear Drs. Isham and McGlynn:

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 2015 Considerations for Implementing Measures in Federal Programs draft report. The AAMC is a not-for-profit association representing all 141 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans' Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians. 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 preliminary MAP recommendations for hospitals and clinicians.

Readmissions and Other Accountability Measures Should Be Adjusted for Sociodemographic Status (SDS)

The AAMC has long supported appropriate adjustment for sociodemographic status (SDS) factors for certain outcome measures. The Hospital MAP Workgroup had a comprehensive discussion about the upcoming trial period starting January 2015, where NQF will test SDS adjusted measures. The AAMC agrees with the preliminary recommendations that certain measures, including pneumonia 30-day readmissions, the readmissions hybrid e-measure, and the all-cause days in acute care following heart failure, acute myocardial infarction, and pneumonia should undergo review in the SDS trial period to determine whether there is a conceptual and empirical relationship between outcomes and SDS factors.

The AAMC strongly supports a robust and transparent SDS trial period and asks that the MAP re-review these measures for appropriateness in federal programs upon its completion. The AAMC also notes, however, that there are several measures in the current performance programs

(such as readmissions) which have not been SDS adjusted. We ask that MAP include a comment about the need to adjust the existing measures as well.

Overlapping Measures between Hospital Acquired Condition Reduction Program (HACRP) and Value-based Purchasing Program (VBP) Is Not Alignment

The MAP draft report's section on the Hospital Acquired Condition Reduction Program (HACRP) [starting page 7] states "the measures in this program overlap with those in the Hospital [Value Based Purchasing] VBP, helping to support alignment and focus attention on these critical safety issues." The AAMC strongly supports alignment in quality reporting, but disagrees that having overlapping measures in VBP and HACRP necessarily promotes that goal. Hospitals can be penalized twice for having one event and overlapping measures can lead to confusion to providers and consumers if an institution performs well in one program and not as well in another. Finally, it can lead to confusion when reviewing measures for programs. For example, the Hospital Workgroup reviewed two revised measures, CLABSI (Central Line Associated Blood Stream Infection) and CAUTI (Catheter Associated Urinary Tract Infection), for two programs: HACRP and the VBP Program. The comments for these measures are virtually identical, yet the revised measures were "conditionally supported" for VBP and "supported" for HACRP. The MAP report did not explain why the two programs had differing recommendations. The AAMC asks the MAP to clarify why the recommendations differ and include an additional sentence in the report noting the potential confusion and negative consequences of having overlapping measures between programs.

MAP Should Perform Holistic Review of Measures

The AAMC believes that the MAP Workgroups should review measures in the Medicare programs holistically in order to ensure that new measures add value, are useful for consumers, and promote alignment, while also considering the burden to reporting these measures for providers. While only new or revised measures are reviewed by the MAP, a comprehensive review can only occur when the committee considers the data collection burden imposed by existing measures.

Hospital Performance Program Measures Should be Publicly Reported Prior to MAP Review

In this year's MUC list, CMS included new or revised measures for possible inclusion in Medicare hospital quality performance programs. The AAMC is concerned that several measures have not been publicly reported, which limits the public's ability to provide feedback. Publicly reporting measures in the Inpatient Quality Reporting (IQR) Program allows MAP Workgroup stakeholders to be fully informed regarding any complications in submitting the measures, and allows time to identify errors, unintended consequences, or other concerns with the measure's methodology.

Caution against Using Claims-Based and Self-Reported Measures for Clinical Events

Administrative claims are designed for billing purposes and are less accurate in identifying a patient's clinical profile than clinical data abstracted from the medical record. The AAMC has concerns about adding new claims-based or self-reported measures to accountability programs, where variations in data collection can affect performance. Therefore, the AAMC does not believe that the claims-based death among surgical inpatients with serious, treatable complications (PSI 4) should be recommended for the VBP Program.

Acknowledge Complexity in Clinician Measurement

Medicare clinician reporting programs are complex and interconnected. While the draft MAP report does an excellent job of summarizing the measures available for reporting (particularly Table 1: Progress to High-Value Measures), the reality is that most physicians are not able to simply choose from the list of measures in the Physician Quality Reporting System (PQRS). Not all measures are available for all reporting options, and not all reported measures are captured in Table 1. Some PQRS reporting options allow clinicians to select their measures; while other options require the clinician to report on the same set of measures. Individual clinicians and group practices have to review the rules of PQRS, the Value Modifier (VM), and Electronic Health Record (EHR) Incentive Programs, and the associated measures, to find the options that are the most effective for its practice. Another complexity for physician reporting is that some reviewed measures are voluntary through PQRS, while other measures, such as the additional quality and cost measures in the VM, are reported to all clinician practices.

The AAMC requests that MAP add context around Table 1, noting the complexity of the reporting and that not all measures are available for all reporting options. In the future, MAP may also want to consider the non-voluntary VM quality and cost measures in its own consent calendar. Finally, the AAMC encourages CMS to continue aligning the three programs and reduce the complexity of and burden of reporting.

Thank you for consideration of these comments. If you have questions, please contact Scott Wetzel (swetzel@aamc.org, 202-828-0495) or myself (mwheatley@aamc.org, 202-862-6297).

Sincerely,

Mary Wheatley
Director, Quality and Physician Payment Policies

cc: Janis Orłowski, AAMC
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