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January 11, 2018

Charles Kahn, III, MPH
Harold Pincus, MD
Co-Chairs, Measure Applications Partnership Coordinating Committee
C/O National Quality Forum
1030 15th St NW, Suite 800
Washington, DC 20005

RE: January 2018 Measure Applications Partnership Pre-Rulemaking Draft Report

Dear Mr. Kahn and Dr. Pincus:

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 2018 Considerations for Implementing Measures in Federal Programs draft report. The AAMC is a not-for-profit association representing all 149 accredited U.S. and 17 accredited Canadian medical schools; over 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic and scientific societies. Through these institutions and organizations, the AAMC represents 167,000 faculty members, 88,000 medical students, and 124,000 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 MAP recommendations for both hospitals and clinicians:

- Regarding the clinician measures under consideration, the AAMC strongly believes that providers should not be held accountable for activities outside their control. The 8 episode level cost measures must be appropriately risk adjusted, including for social risk factors, and the attribution methodology for episodes should clearly and accurately determine the relationship between patient and clinician before such episode-level cost measures are incorporated into the Quality Payment Program.

- For the hospital measures, the AAMC strongly believes that certain accountability measures must be adjusted for sociodemographic status (SDS) before being included in the Medicare quality reporting programs, be NQF-endorsed prior to MAP review, and be included in the Inpatient Quality Reporting (IQR) program for at least one year before being considered in a performance program by the Workgroup. Additionally, the AAMC recommends that the report acknowledge the challenges in voting that occurred during the MAP Hospital Workgroup meeting.

- 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. The AAMC notes that CMS' Meaningful Measures framework is a starting point

toward this work, and supports the MAP Hospital Workgroup's suggestion that CMS increase harmonization of measures and evaluate similar constructs across settings and programs. The AAMC believes that increased harmonization includes harmonization of measure implementation, and that the MAP was correct to note that variation in how a measure is implemented creates challenges for patients and providers. Additionally, the AAMC is supportive of an active MAP role in examining measures used in CMS programs more broadly, due to the amplified impact of the measures as other payers and purchasers often implement measures used by CMS.

- Finally, the AAMC agrees with MAP Workgroup feedback to CMS in regards to which criteria CMS should consider when removing measures from its quality reporting and value-based purchasing programs. Specifically, the AAMC is supportive of the MAP Hospital Workgroup's additional suggested criteria and items to consider, particularly risk adjustment, provider burden, and operational issues.

MAP Clinician Workgroup Comments

The draft MAP report, titled "Considerations for Implementing Measures in Federal Programs" reviews the Clinician Workgroup discussion regarding the measures under consideration for the Merit-Based Incentive Payment System (MIPS) and the Medicare Shared Savings Program. CMS identified key program needs and priorities for the MIPS program, including cost and composite measures, measures relevant to specialty providers, domains of person and caregiver experience and outcomes, and appropriate use.

One copy editing note is that the draft report appears to have an inconsistency. The spreadsheet "map_2017-2018_preliminary_recommendations" posted to the MAP Coordinating Committee web indicates that the MAP Clinician Workgroup conditionally supported eighteen measures for MIPS, but in the report, atop page 6, it states that the "MAP conditionally supported nineteen measures."

Cost Measures Should be Appropriately Risk-Adjusted and the Attribution Methodology Should be Clear and Accurately Determine Patient/Clinician Relationship

Cost measures have been identified as a priority, and CMS addressed this priority through the inclusion of 8 cost measures on the MUC list for discussion during the MAP Clinician Workgroup meeting. The AAMC remains concerned that none of the 8 cost measures are adjusted to account for socio-demographic status (SDS). In addition to patient clinical complexity, SDS factors 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 addition, we echo the MAP's cautious concern for potential care stinting as an unintended consequence of cost measures, and agree that appropriate risk adjustment may help safeguard against that practice. In regards 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. **The AAMC recommends that: (1) cost measures include risk-adjustment for SDS**

factors, (2) the attribution methodology is transparent, and (3) the correct clinician is held responsible for the patient's outcomes and costs.

Composite Measures Should Only Be Used When Fully Developed, Technically Feasible, and Actionable

The MAP expressed encouragement for additional composite measures under consideration, and acknowledged the additional technical challenges that composite measures pose during the measure development process, noting an adult vaccine composite measure might be preferred over individual measures for vaccine administration, but that such a composite measure might be challenging to develop and maintain due to changing clinical guidelines. In regards to condition specific composite measures, the MAP noted that composite measures may provide challenges at the clinician level where a particular clinician or specialist does not have complete control over the care for that particular condition. **The AAMC supports composite measures, but only when the composite measure is fully developed and vetted, technically feasible, and actionable at the individual-clinician level.**

MAP Hospital Workgroup Comments

Address Challenges Related to MAP Voting in the Draft Report

During the December MAP Hospital Workgroup there was significant discussion about the workgroup's voting process, most notably when the chairs re-visited the morning's voting on two of the three measures under consideration for the End-Stage Renal Disease Quality Incentive Program (ESRD QIP). This discussion around the lack of clarity around the voting process was an important part of the workgroup's deliberation on the considerations for implementing measures in federal programs. In particular, there was concern about "what" Workgroup members were actually voting on for a given vote, and what the thresholds were for motion passage. Overall, the voting process was inconsistent and not truly reflective of Workgroup consensus. These issues must be clarified prior to any future voting by the committee. **The AAMC recommends that the challenges and concerns with the voting process related to these measures be acknowledged in the report and be addressed prior to future MAP meetings.**

Accountability Measures Must Be Adjusted for Sociodemographic Status (SDS)

The AAMC has long advocated for appropriate adjustment for sociodemographic status (SDS) factors for certain outcome measures. The AAMC agrees with the Workgroup's preliminary recommendations that the pneumonia episode-of-care payment and excess days in acute care after hospitalization measures should undergo review in the SDS trial period to determine whether there is a conceptual and empirical relationship between outcomes and SDS factors prior to inclusion in the IQR program. The Association also strongly believes that other approved Hospital MAP Workgroup measures, including hospital visits within 7 days after hospital outpatient surgery and CABG mortality, should be submitted for review in the SDS trial period.

The AAMC strongly supports a continued robust and transparent SDS trial period. The Association is very concerned that the issues and concerns regarding SDS are not being sufficiently addressed. We ask that the SDS trial period be a priority for the MAP, NQF, and CMS in 2018 and subsequent

years. The AAMC also notes that there are several measures in the current performance programs which have not been SDS adjusted. **We ask that MAP include a recommendation regarding the need to adjust the existing measures for SDS, and that an opportunity be provided to review all measures for appropriateness in the performance programs.**

All Measures Reviewed by the MAP Hospital Workgroup Should be NQF Endorsed

NQF endorsement demonstrates that a measure has been tested, is reliable, and can be used in a specific setting. With the volume of measures the MAP has to review, the Workgroups and Coordinating Committee rely heavily on NQF endorsement to ensure the measure is sound. Since hospital measures are typically not re-reviewed by the Workgroup, it is essential that these measures be NQF-endorsed at the time of consideration so that members are fully informed as to the measure's appropriateness for the Medicare reporting and performance programs. The voting on measures under consideration demonstrated that there is a narrow consensus by the MAP hospital workgroup to conditionally support measures pending NQF endorsement, and that there is a large minority with major concern about CMS pushing a measure to the workgroup before it is fully vetted and understood. **The AAMC echoes the MAP members' concerns regarding how best to provide recommendations to CMS on measures that are not fully developed and tested or measures that have not been examined for their scientific acceptability.**

Individual Measure Review

ESRD Program: Percentage of Prevalent Patients Waitlisted (PPW)

During the MAP Hospital Workgroup meeting, there was considerable discussion regarding the measure of the percentage of patients waitlisted for a kidney transplant (MUC 17-241). While the AAMC agrees with the importance of improving transplantation rates for all patients with ESRD and recognize the issues of equal access to transplantation, we do not support the attribution of this measure to dialysis facilities. Referral for transplantation is a decision made by the nephrologist and waitlisting is a decision that is made by the transplant center neither decision is under the control of a dialysis facility. There may be clinical reasons that a patient is not eligible for a transplant and those decisions should be made by a physician responsible for the patient's care and by the patient. These are complex decisions that take into account many factors. There are demographic issues depending on the location of the facility that may make nationwide comparisons of waitlists percentages difficult to interpret.

As the NQF and CMS consider measures for inclusion in programs, it is critical to ensure that these measures are meaningful to the providers and to the consumers. We are concerned about unintended consequences that may occur if this measure were implemented in the ESRD program, particularly due to the attribution concerns.

Hospital-Wide All-Cause Mortality Measure

The Hospital MAP Workgroup conditionally supported a new hospital-wide all-cause risk standardized mortality measure (MUC17-195) pending review and endorsement, specifically recommending that the NQF committee reviewing the measure ensure that there is appropriate, validated evidence supporting the measure and explicitly consider the importance of the measure and potential unintended consequences. It was also recommended that the measure be brought to the

NQF Disparities Standing Committee as part of the evaluation for appropriateness of adjusting for social risk factors. The AAMC appreciates that the MAP's discussion that an all-cause mortality measure is of great importance to patients and could potentially encourage facilities to work more collaboratively with other providers and improve continuity of care.

However, serious concerns relating to risk adjustment, misuse of all-cause mortality metrics used in epidemiological studies, unintended consequences for end-of-life care, misinterpretation of the measure score by consumers discussed were raised, and it is essential that these concerns be vetted through the NQF endorsement process.

Claims-based risk adjustment by using HCC data might not adequately account for appropriate clinical and social risk factors and does not broadly capture the patient's health status. Hospitals that disproportionately care for vulnerable patient populations are disadvantaged when SDS factors are not considered in the risk adjustment or scoring methodology. The AAMC agrees with the MAP that appropriate risk adjustment is necessary to ensure that the measure does not disproportionately penalize facilities who see more complex patients.

Appropriate exclusions should address hospice enrollment to ensure that the timing of hospice decisions by a patient's family that results in a delay in enrollment such that the patient's admission is inappropriately included when measuring a hospital's mortality rate. The AAMC shares the concerns raised by the National Coalition for Hospice and Palliative Care that as proposed, this measure may have the unintended consequence of "inhibit[ing] the use of palliative services and failure to accommodate the wishes of patients who would prefer death over prolonged life-sustaining treatment."

The AAMC believes that condition-specific mortality measures already in use in the IQR may be more actionable for hospitals and may provide more detailed information to patients to support consumer decision-making. We agree with the MAP members who cautioned that performance scores on an all-cause mortality measure could be potentially misleading to consumers, as this may simply reflect a lower acuity facility and not necessarily a facility's overall quality.

For all of the reasons above, **the AAMC continues to strongly believe that these concerns weigh against conditional support of the measure for the Hospital Inpatient Quality Reporting (IQR) program.**

Hybrid Hospital-Wide All-Cause Mortality Measure

The Hospital MAP Workgroup also conditionally supported a new hybrid hospital-wide all-cause risk standardized mortality measure (MUC17-196) pending review and endorsement with enumerated recommendations for the Standing Committee in its review of the measure, including that the Standing Committee pay specific attention to the ability to consistently obtain EHR data across hospitals. The MAP also recommended that there be a voluntary reporting period for the measure before it is finalized in the IQR program in order to allow providers to test the extraction of electronic data elements. The AAMC agrees with the voluntary reporting recommendation, but continues to strongly believe that the overall concerns with hospital-wide all-cause mortality measures (as discussed above) plus the additional concerns described below related to this hybrid measure weighed against conditional support of the measure for the IQR program.

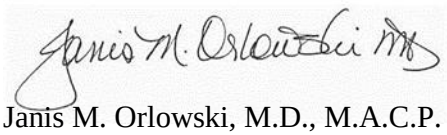
The AAMC understands that CMS' intention is to replace MUC17-195 with this hybrid all-cause mortality measure once the hybrid measure is fully developed and endorsed. The MAP noted that the concerns for the claims-based mortality measure were the same for this measure, in addition to concerns with the challenges of extracting EHR data and EHR fragmentation. The AAMC believes that integrating EHR data with claims data is a positive step, but we recommend that the focus of efforts at this stage should be on the use of EHR data to adjust condition specific mortality measures that are currently being used in the programs.

Additionally, the AAMC would like to note that there was discussion around concern that this measure was developed using Kaiser Permanente Northern California data in the model, and that such data is not representative of Medicare Fee for Service more broadly. This was not included in the draft report, and the AAMC recommends that this concern be acknowledged in the final report.

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,



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cc: Gayle Lee, AAMC
Phoebe Ramsey, AAMC