AAMC Association of American Medical Colleges

September 11, 2018

Mr. Adam Boehler
Director, Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: Bundled Payments for Care Improvement Advanced

Dear Director Boehler:

The AAMC is a not-for-profit association representing all 151 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, and 80 academic and scientific societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 173,000 full-time faculty members, 89,000 medical students, and 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 actively supports over 50 academic health systems and their providers that participate in Medicare bundled payment programs. As a facilitator convener under the Bundled Payments for Care Improvement (BPCI) initiative, the AAMC has a deep interest in the promise of bundled payments to create the right incentives for the provision of value-based care. The AAMC also provides support for providers implementing the Comprehensive Care for Joint Replacement (CJR) model, the Oncology Care Model (OCM), and most recently BPCI Advanced. The lessons garnered from this experience heavily inform the content of the AAMC's comments.

We share CMMI's commitment to value-based care and believe that CMMI's leadership will continue to accelerate this transition, specifically through models such as BPCI Advanced. We appreciate CMMI's responsiveness to stakeholder feedback, as evidenced by the recent inclusion of Episode IDs in monthly performance period data releases. However, we are concerned that the inclusion of PSI-90 in the Composite Quality Score (CQS) methodology, as currently specified, is premature and may disadvantage academic medical center (AMC) participants. Furthermore, we remain concerned that the level of detail CMMI intends to provide in performance period data will not provide participants with sufficient information to make actionable improvements to quality or cost.

To enable Participants to succeed in BPCI Advanced and make the performance period data actionable, we urge CMMI to adopt the following technical refinements:

1. Eliminate PSI-90 from the CQS methodology, unless CMMI adequately addresses the significant methodological limitations (as detailed below);

2. Release a monthly beneficiary file indicating included/excluded beneficiaries and additional beneficiary identifiers; and
3. Refresh past performance period claims data upon releasing the current monthly file.

We thank you for your consideration of these three requests, which we explain in detail below.

1. PSI-90 Quality Measure Concerns

The BPCI Advanced model will apply the composite quality measure PSI-90 to all Clinical Episodes. As we have commented on the FY 2017 and 2018 IPPS Proposed Rules, the PSI-90 composite measure is flawed. The AAMC is concerned that CMMI has not yet released specifications about how it intends to apply this measure, and believes that PSI-90 may not reliably measure clinical quality. ***The AAMC strongly recommends eliminating PSI-90 from the CQS methodology, based on the significant methodological limitations detailed below. However, if CMMI retains PSI-90 in BPCI Advanced, then it is imperative that CMMI specify the composite for ICD-10; adequately risk adjust the measure; test PSI-90 for validity through the Hospital Inpatient Quality Reporting (HIQR) program; and apply P4R for the first period in which the measure is used.***

The PSI-90 composite quality measure has three primary methodological limitations:

1. PSI-90 has not yet been updated with ICD-10 specifications or used for the HIQR program;
2. PSI-90 was designed to apply at the hospital rather than episode level, which raises concerns about its reliability due to the potential for small sample size; and
3. PSI-90 is not risk adjusted for patient case mix, which means it does not account for patients' comorbidities and may not adequately measure the quality of clinical care.

The first limitation is that while the individual component measures have been specified for ICD-10 for observed rates, the PSI-90 composite measure methodology has not been specified for ICD-10. This leads to potential inaccuracies and limited comparability between the baseline and performance period. Currently, if Participants attempted to calculate their PSI-90 measure, Participants could only utilize claims billed with ICD-9 codes through the third quarter of 2015. Although Participants could utilize General Equivalence Mappings (GEMS) to convert claims billed with ICD-9 to ICD-10, the additional specificity of ICD-10 codes creates additional challenges and weakens the conversion. In some cases, the new specificity drastically changes the PSI rates calculated using claims with ICD-10 codes, limiting the comparability of the estimates.

The second limitation is that the PSI-90 composite measure currently measures hospitals at the facility level, while BPCI Advanced intends to apply the measure at the episode level. CMMI has not released specifications on how it intends to modify PSI-90 to measure the composite at an episode level. Despite the absence of CMMI guidance, the AAMC is concerned that the measure may be susceptible to variations in sample size. PSI-90 currently assigns each component measure a different denominator, some of which depend on the episode (e.g., some PSI components are surgical-based). Because the denominator for each component may be based

on the number of episodes, the sample size at the episode level will be incredibly small for very rare events, making the measure extremely sensitive to variation in sample size. The AAMC has observed large variability in the PSI-90 measure based on each release, where the individual measure weights within the composite change each year, sometimes drastically. This makes it challenging at the facility-level to target improvements.

The third limitation is that PSI-90 may not be valid due to the lack of risk adjustment for both the component and composite measures. This creates additional challenges for AMCs, which treat a higher proportion of complex and disadvantaged patients. Frequently, the outcomes of many of the PSI-90 component measures are due to patients' comorbidities, rather than the delivery of care. As a result, AMCs treating more medically complex patients may be disadvantaged by the inclusion of PSI-90 in the CQS methodology, meaning that their investments in care redesign may appear to be of minimal impact under the current methodology.

2. Monthly Performance Period Beneficiary Files Support Targeted Interventions

It is imperative that CMMI include a monthly beneficiary file indicating included/excluded beneficiaries and additional beneficiary identifiers. CMMI currently provides BPCI and CJR Participants with episode and beneficiary files containing this information as part of monthly data releases, and this has proven invaluable in Participants' implementation of the models. As currently designed, BPCI Advanced will omit the beneficiary file from monthly performance period data, which introduces two unnecessary program risks related to clinical quality improvement and financial uncertainty.

First, Participants will not be able to improve patient care in real time by linking claims with clinical data, which will limit their ability to improve care quality through data analysis. Providers participating in BPCI, CJR, and OCM often utilize the medical record number (MRN) to link claims data to clinical data contained in the EHR. The omission of fields generally included in the beneficiary file—such as patient name, date of birth, and MRN—will hinder Participants' ability to conduct robust analyses that include both claims and clinical data to improve quality (e.g., identification of the root causes of readmissions).

Second, Participants will not be able to accurately identify their eligible beneficiaries, resulting in increased uncertainty and financial risk. For example, a beneficiary may be eligible for BPCI Advanced at the time of admission, but subsequently enroll in Medicare Advantage during the 90 days following discharge, resulting in CMMI's exclusion of the beneficiary's episode at reconciliation. However, during the performance period, Participants would assume that the beneficiary's episode would be attributed to them, which they would factor into their financial projections for BPCI Advanced performance. When a large percentage of episodes are ultimately dropped at reconciliation due to exclusion criteria, this significantly reduces episode volume, increasing the chance that random variation will drive financial performance. Accurate and predictable episode attribution is crucial to provider success in APMs such as BPCI Advanced.

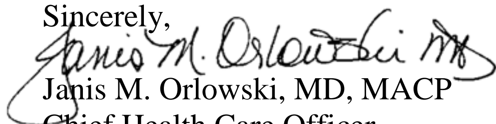
3. **Refreshes of Past Performance Period Claims Data Facilitate Participation in APMs**

The existing bundled payment programs (e.g., BPCI Classic, CJR and OCM) currently provide full refreshes of past performance period claims data. Although full refreshes of OCM claims were not provided initially, the OCM team later acknowledged the importance of refreshes by modifying their policy, and now refresh three additional quarters upon the release of the most recent quarter of data (e.g. refreshing the files from October 2018 through February 2019 when releasing the March 2019 monthly file). This policy enables practices to analyze complete performance period data, accounting for claims lag. ***Building on the lessons of OCM, we encourage CMMI to fully refresh past performance period claims data when releasing BPCI Advanced monthly files.***

Conclusion

We are committed to the transition from volume to value and believe that BPCI Advanced will accelerate this change. We appreciate CMMI's consideration of our suggestions for enhancing this Model. If you have questions, please do not hesitate to contact Lauren Kuenstner at 202-741-5516 or lkuenstner@aamc.org, or Theresa Dreyer at 202-744-4673 or tdreyer@aamc.org..

Sincerely,



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