



Association of
American Medical Colleges
655 K Street, NW, Suite 100, Washington, DC 20001-2399
T 202 828 0400
aamc.org

Submitted electronically to MIPSOoutcomesmeasures@yale.edu

May 24, 2019

Kate Goodrich, MD
Director, Center for Clinical Standards and Quality
Chief Medical Officer, Centers for Medicare and Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: Request for Public Comment on Measure Methodology Report: Clinician and Clinician Group Risk-standardized Hospital Admissions Rates for Patients with Multiple Chronic Conditions

Dear Dr. Goodrich:

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Measures Methodology Report: Clinician and Clinician Group Risk-standardized Hospital Admissions Rates for Patients with Multiple Chronic Conditions, prepared for CMS by Yale New Haven Health Center for Outcomes Evaluation and Research (CORE).

The AAMC is a not-for-profit association dedicated to transforming health care through innovated medical education, cutting-edge patient care, and groundbreaking medical research. Its 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 biomedical sciences.

The AAMC appreciates the opportunity to comment on this report, which presents a newly adapted measure for use in the Merit-based Incentive Payment System (MIPS), currently described as a measure of acute, unplanned hospital admissions for patients with multiple chronic conditions (MCCs) that CMS currently reports for Medicare Accountable Care Organizations (ACOs). The new measure is a risk-adjusted measure that uses the outcome of acute, unplanned 100 person-years at risk of hospital admission to assess care quality. Additionally, the existing measure was adjusted to capture attribution, as Medicare beneficiaries typically see multiple health care providers in the outpatient setting. Patients are attributed to

eligible clinicians using a visit-based algorithm that assigns patients to the primary care provider (PCP) with the most visits, unless there is a dominant specialist coordinating care.

The AAMC is appreciative that the report clearly outlines the rationale for this new measure and of the thoughtful process to determine attribution methodology. However, there were several items that were not clearly outlined in the report, which we will provide additional comment on below.

Evidence Supporting the Measure

While CMS provides evidence in this report to demonstrate that improved care coordination can lead to reductions in hospital admissions, the majority of the evidence cited involved multiple partners on the care coordination team, such as health systems and/or hospitals. The report also does not provide a strong evidence base to support the premise that a physician can drive improvement in the absence of a program involving other partners or payment incentive to account for the time spent on activities like care coordination. The AAMC feels that including these partners in care coordination or in programs and efforts focused on care management would be beneficial and suggests that CMS consider incorporating a payment incentive for these efforts.

Attribution Approach

The AAMC appreciates that this report adequately describes the various attribution options that were explored for both individual and group assignment of patients, and the National Quality Forum's (NQF) principles for selection of an attribution model. However, a clinician or clinician group's ability to drive improvements on this measure is limited due to the chosen retrospective attribution model. Retrospective attribution can make it difficult for clinicians to influence reductions in admissions.

The AAMC is supportive of efforts to determine which physician is the "quarterback" for patient care, instead of having multiple providers assigned to one beneficiary. The AAMC feels that this attribution model will allow the measure to be as accurate as possible and capture the data from the most relevant patient interaction. We appreciate that the report took into account the fact that the patient may also be regularly seeing a specialist provider who may be a more effective "quarterback" for the beneficiary than their primary care physician, especially for a beneficiary with multiple chronic conditions (MCCs). The AAMC is supportive of this flexibility as it will allow for more meaningful measurement.

Risk Adjustment

There is significant peer-reviewed literature¹ demonstrating that a performance on outcomes can be affected by factors outside the control of the physician (e.g. housing, food insecurity, social support, transportation). The AAMC appreciates that CMS has agreed to include AHRQ

¹ See National Academies of Sciences, Engineering, and Medicine. 2016-2017. *Report Series: Accounting for Social Risk Factors in Medicare Payment*. Washington, DC: The National Academies Press. Details here: <http://www.nationalacademies.org/hmd/Activities/Quality/Accounting-SES-in-Medicare-Payment-Programs.aspx>

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Socioeconomic Status (SES) index and specialist density as part of the adjustment for social risk factors. However, Yale CORE tested the social risk factors after assessment of clinical and demographic risk factors. It remains unclear why this multi-step approach was used, as it appears to be contrary to the guidance that the NQF Disparities Standing Committee has provided.

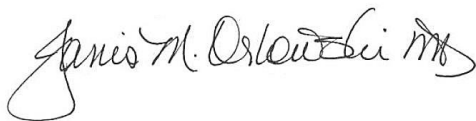
CMS requested specific input on whether the measure should also be adjusted for dual eligibility. There is precedent for this adjustment in the hospital readmissions program where CMS has implemented some risk adjustment by stratifying penalties by the proportion of Medicare and Medicaid dual eligible patients the hospital serves. As a first step, we believe it is appropriate to adjust this measure for dual eligible status. We believe adjustments for SES should be considered at the overall MIPS group and individual level and at the measure level to make accurate quality comparisons. CMS also needs to explore additional social risk factors beyond dual eligible status that impact performance on quality

Reliability and Validity Testing

Yale's report clearly outlines the options for the individual clinician attribution approach, along with the rationale on why one approach was selected over the other. Unfortunately, the report does not provide the same information on which of the two options were selected for group attribution. As a result of this, it is unclear what attribution approach was used in the testing at the group level. The AAMC asks that CMS provide additional information on the approach and rationale for which attribution approach was used in the testing at the group level.

The AAMC appreciates the opportunity to comment on this report, and we look forward to continued engagement on these important issues. If you have any questions, please contact Gayle Lee at (202) 741-6429 or galee@aamc.org

Sincerely,



Janis M. Orlowski, MD, MACP
Chief Health Care Officers

Cc:

Ivy Baer, JD MPH, AAMC
Gayle Lee, JD, AAMC
Phoebe Ramsey, JD, AAMC