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To: Pre-Rulemaking Measure Review (PRMR) Clinician Committee
(via the Partnership for Quality Measurement Submission Portal)
Date: December 22, 2023
Re: AAMC Comments on 2023-24 MUC List – Clinician Measures

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment in advance of the Partnership for Quality Measurement's PRMR Measure Applications Partnership's Clinician Committee meeting to consider recommendations in response to the Centers for Medicare & Medicaid Services' (CMS) 2023-24 Measures Under Consideration (MUC) list.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 157 U.S. medical schools accredited by the Liaison Committee on Medical Education; 12 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers. Learn more at aamc.org.

The following are the AAMC's high-level comments on the measures under consideration for CMS programs:

- For all measures, the AAMC continues to strongly believe that measures included on the MUC list be fully specified and endorsed by a consensus-based entity *prior* to PRMR review.
- Measures must be evaluated within a given quality program and its measure set and for wider priority areas – most notably health care equity.
- Health care providers should not be held accountable for that which is outside their control. Measures must be valid and reliable at the program's specified measurement-level (i.e., hospital, clinician, or practice group level) – a measure re-specified for use in another setting must demonstrate validity and reliability for that setting.

Comments on Select Measures Before the Clinician Workgroup

Measures for Medicare Part C & D Star Rating

The "Level 1 Denials Upheld Rate Measure" is under consideration for inclusion in Medicare Part C and D Ratings. This measure would assess Medicare Part C (Medicare Advantage) plans on the rate

at which Level 1 appeals of prior authorization request denials reviewed by health plans internally find the original determination to deny coverage to be reasonable. There is currently a measure that focuses on Level 2 appeals, which are reviewed by an external independent reviewer. By adding a complementary measure with focus on Level 1 appeals, which occur earlier in the process, plan enrollees (and potential future enrollees) can assess the rate at which plans uphold prior authorization denials and whether the plan is able to efficiently ensure that patients are able to get necessary care in a timely and appropriate manner. This is especially critical in consideration of the U.S. Department of Health and Human Services Office of Inspector General Report finding improper denials by some Medicare Advantage plans raising concerns about patient access to medically necessary care in the Part C program.[1] The measure is meaningful to patients and health care providers, and measure documentation demonstrates high reliability and usability in the specified program. **The AAMC supports recommending this measure for future use in the Medicare Part C Star Rating.**

Quality Measures for the Merit-based Incentive Payment System (MIPS)

The following are quality measures under consideration for inclusion in the MIPS Quality performance category:

- Positive PD-L1 Biomarker Expression Test Result Prior to First-Line Immune Checkpoint Inhibitor Therapy
- Appropriate Germline Testing for Ovarian Cancer Patients
- Patient-Reported Pain Interference Following Chemotherapy among Adults with Breast Cancer
- Adult COVID-19 Vaccination Status
- Patient-Reported Fatigue Following Chemotherapy among Adults with Breast Cancer
- Melanoma: Tracking and Evaluation of Recurrence

New Quality Measures Should Be Considered in Relation to Inclusion in MIPS Value Pathway (MVP) Measure Sets

Measure materials do not include any information as to how these quality measures will or will not be transitioned into MVP measure sets. The MVP framework is the future direction of MIPS participation under the Quality Payment Program and will require quality measures be reported within a broader specialty MVP measure set.

Cost Measures for MIPS

The cost measures under consideration for inclusion in the MIPS Cost performance category are:

- Cataract Removal with Intraocular Implantation
- Chronic Kidney Disease
- End-Stage Renal Disease

[1] *See* U.S. Department of Health and Human Services Office of the Inspector General, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (2022).

- Inpatient (IP) Percutaneous Coronary Intervention
- Kidney Transplant Management
- Prostate Cancer
- Respiratory Infection Hospitalization
- Rheumatoid Arthritis

Cost Measures Should Include Appropriate Risk Adjustment for Health-related Social Needs

These episode cost measures are risk-adjusted by demographic variables, such as age, and comorbidities by using Hierarchical Condition Categories (HCC) data, and other clinical characteristics. Of special concern is that none of the cost measures are adjusted to account for health-related social risk factors. In addition to differences in patient clinical complexity, health-related social needs can drive differences in average episode costs. The National Academies of Science, Engineering and Medicine and the HHS Assistant Secretary for Planning and Evaluation have clearly acknowledged that social risk factors such as housing instability, low income, and health literacy may explain adverse outcomes and higher costs.[2] Cost measures must be appropriately specified to ensure all patients can access and receive all necessary care. Physicians at academic medical systems often care for patients from under resourced and underinvested communities and who may have more complex clinical and social needs than many patients treated elsewhere, and without adjustment are likely to have distorted cost outcomes. Therefore, we request that these cost measures be evaluated as to whether they appropriately account for these health-related social needs to present an equitable picture of the cost of care.

Attribution Methods Should be Clear and Transparent and Correctly Capture the Patient/Clinician Relationship

It is critical for cost measures to reflect an accurate determination of the relationship between a patient and a clinician to ensure that clinicians are appropriately held responsible for their patient's outcomes and costs. This is complicated given that many patients receive care from numerous clinicians, and potentially across several facilities and practices. Furthermore, physician practices within academic medical centers have moved towards delivering team-based care. Team-based care allows clinicians to work as a multispecialty team partnering with their patients and their families to address medical conditions and provide comprehensive care. Potential cost measures must ensure that the attribution process encourages team-based care rather than incentivizes siloed care. AAMC continues to urge CMS and measure developers to explore better data sources and analytic techniques to support more accurate attribution. We recommend that the Committee evaluate the attribution methods of these measures under consideration on whether the attribution is clear, transparent, and easily understood by clinicians.

Conclusion

The AAMC appreciates your consideration of the above comments. Should you have any questions regarding these comments, please contact Phoebe Ramsey (pramsey@aamc.org) and Ki Stewart (kstewart@aamc.org).

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[2] *See* National Academies of Science, Engineering and Medicine, Accounting for Social Risk Factors in Medicare Payment (2016).