American College of Physicians
Leading Internal Medicine, Improving Lives

September 17, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator Verma:

The American College of Physicians (ACP) appreciates the opportunity to comment as the Centers for Medicare & Medicaid Services (CMS) and Acumen continue to develop and field test new episode-based cost measures. ACP is the largest medical specialty organization and the second largest physician membership society in the United States comprised of 163,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum of care from health to complex illness.

Episode-based cost measures represent an important opportunity to move towards more accurate, targeted cost assessment in value-based programs and models. However, ACP has concerns with several of the specific methods and methodologies proposed related to patient attribution, risk adjustment, etc. Getting these details right is critical to the accuracy and future success of cost measurement. ACP expands on these thoughts below in the context of cost measurement more generally and the "Wave 3" measures currently undergoing field-testing that are most relevant to internal medicine (sepsis, diabetes, and asthma/COPD).

Introduction of Chronic Condition Episode-Based Cost Measures

ACP supports and encourages the development of episode-based cost measures for chronic conditions. Ninety percent of U.S. healthcare expenditures are for patients with mental and chronic health conditions.[1] Monitoring and encouraging cost reductions in this area represents a potentially major opportunity to reduce spending without reducing patient access, choice, or quality of care.

Risk Adjustment

This said, it is critical to get risk adjustment right, particularly when it comes to measuring cost. Failing to properly risk adjust for socioeconomic, biological, or other factors that put patients at increased risk could jeopardize funding for hospitals and practices serving our nation's most vulnerable populations and potentially threaten access to medical services for those patients as a result.[2] **The implications of the risk-adjustment model for the episode-based cost measures currently undergoing field-testing are unclear.** The model estimates expected episode costs, recognizing different levels of care may be

[1] www.cdc.gov/chronicdisease/about/costs/index.htm#ref1

[2] www.acponline.org/acp_policy/policies/racial_ethnic_disparities_2010.pdf

required due to comorbidities, disability, age, and other risk factors. This model is not sufficient to control for all significant social determinants of health (SDOH) that may influence the clinical health status of patients as well as patient outcomes. ACP strongly believes better understanding and ameliorating SDOH is critical to an improved healthcare system.[3] Accordingly, **ACP calls on CMS to revise the risk-adjustment model to include SDOH that are most likely to influence the clinical health status of the relevant patient population.** Aligning CMS' risk adjustment model with more robust methods for statistical analyses that consider all factors independently and significantly associated with outcomes for particular diseases or patient populations, such as the Society for Thoracic Surgeons Adult Cardiac Surgery Risk Model, would help to enhance the accuracy of risk adjustment. This would help avert potential negative consequences such as unduly penalizing practices that treat vulnerable patient populations, patient "cherry picking," and patient access issues.

Attribution Level

ACP strongly believes all cost measures should be attributed at the group practice level or higher. It is important that cost metrics capture what is actionable and within the control of practicing clinicians, which is extremely difficult to accurately gage and technically challenging to capture at the individual clinician level. Healthcare costs are influenced not by the actions of one clinician but by the actions of multiple clinicians or the healthcare team as well as a patient's social, economic, and environmental factors. It is difficult, if not impossible, to determine the relative influence that an individual clinician has on a patient's expenses. Moreover, this goes against the team-based approach to care that ACP and many others have endorsed as the most effective care delivery framework for its propensity to coordinate care to improve patient outcomes, efficiency of care, and clinician satisfaction.[4] Measuring what is actionable builds long-term buy-in with clinicians, feeds a cycle of participation in value-based programs, and mitigates concerns over possible dysfunctional behaviors such as patient "cherry picking." Stratifying and comparing separate types of costs such indirect costs services under the control of the facility could help identify behaviors that correspond most with opportunities for improvement.

CMS should recognize that accurate, impactful cost measures may not encompass the totality of the cost to Medicare for the items and services provided to a patient during an entire episode of care, or may require assessing savings over multiple years. In any case, the 30% threshold is too low to attribute episode-based care to an individual clinician. CMS should increase the attribution threshold to a higher, evidence-based threshold. **Finally, ACP does <u>not</u> support attributing the same costs to multiple clinicians.** This deviates from the team-based care model and improperly double counts the same costs, which skews cost calculations.

Incorporating Telehealth Services into Cost Calculations

ACP generally supports the incorporation of telehealth services into cost calculations. ACP believes telehealth services meet a critical need to furnish and expand access to critical health services for patients in a safe way, particularly during this Public Health Emergency (PHE), during which use of telehealth services has expanded exponentially.[5] Outside the context of the PHE, telehealth helps to expand access to vulnerable patient populations, such as those living in rural areas, those with mobility

[3] www.acpjournals.org/doi/10.7326/M19-2411

[4] www.acponline.org/acp-newsroom/optimal-team-based-health-care-is-associated-with-improved-patient-outcomes-and-physician-well-being

[5] www.acponline.org/acppolicy/letters/extendingtelehealthpolicychangesafterthePHEjune2020.pdf

issues, etc. In some cases, services delivered via telehealth can be equally as effective as in-person visits and are a critical component of a complete, flexible healthcare delivery service model that is equipped to meet a wide array of patient needs in an efficient and safe manner. Accordingly, **ACP feels it would be appropriate to include these services when calculating cost measures. However, CMS should closely monitor for patterns compared to in-person services and possible unintended consequences.**

Incorporating Part D Drug Costs into Cost Calculations

ACP acknowledges that curbing Part D drug spending is a critical component to controlling overall health spending. The College supports policy solutions that encourage the use of lower-cost generic or biosimilar drugs, such as modifying or eliminating cost-sharing for generic drugs for Part D low-income subsidy enrollees, enacting out of pocket spending caps, and supporting adoption of Medicare Part D negotiation models.[6] While incorporating Part D drug costs into general cost calculations potentially has merit, ACP is concerned about potential adverse consequences that could arise if Part D pricing methodologies are not properly designed and tested. For example, we fear that incorporating Part D drug costs could adversely impact certain medicine specialties that more frequently treat patients that require inherently costly treatments for their complex medical conditions, such as cancer patients. ACP is concerned this could negatively impact patients' ability to access life-saving medications, particularly for those who are low-income. The College has long been an ardent supporter of preserving patient access to their medications.[7] For these reasons, **ACP recommends providing Part D drug cost information on an informational basis to start.** This way, clinicians will have an opportunity to begin familiarizing themselves with and monitoring their Part D drug spending patterns, while allowing CMS and Acumen more time to gather data and closely study the impact of including Part D drug costs, including any trends or potential adverse consequences, before using these to impact physician payments.

Additionally, ACP urges CMS to release more detailed information about including Part D drug costs, including data comparing cost measure results with Part D costs included versus not included, as well as data demonstrating that including Part D drug costs will positively and meaningfully influence clinician spending without leading to patient harm or restricting patient access. **Finally, ACP would encourage CMS to consider risk-adjusting and/or stratifying Part D drug costs by specialty, condition, or patient demographics as appropriate.** We also encourage the Agency to consider when there is a viable, evidence-based, less expensive alternative versus when there is not. In latter cases, CMS should not penalize clinicians for prescribing drugs when there is no viable, cheaper alternative. ACP believes that patient safety should be prioritized above all else when it comes to medication selection. Accordingly, clinicians should not be penalized if a patient experiences side effects on generics or other more cost-effective alternatives and must revert back to a name brand or other more expensive product for his or her own safety. Circumstances like these should be thoughtfully incorporated into any Part D drug cost attribution methodologies.

Outdated Medicare Numbers

Because the test report includes 2018-2019 data, they include outdated Medicare numbers, which creates significant confusion and difficulty. We have heard that practices have attempted to review the

[6] www.acponline.org/acp-newsroom/acp-addresses-high-cost-of-prescription-drugs-in-new-policy-papers

[7] www.acponline.org/system/files/advocacy/currentpolicypapers/assets/controllinghealthcarecosts.pdf

reports that they no longer have access to the outdated numbers through their EHRs. Tracking the data based solely on identifying information like date of service and date of birth is extremely time consuming and will likely severely inhibit the amount of feedback CMS receives. Accordingly, **ACP requests a crosswalk from outdated Medicare numbers to new ones be included for all current and future measures undergoing field-testing.**

Timing

ACP requests additional opportunities to provide feedback on Wave 3 episode-based cost measures. Beyond the crosswalk issue, the timing with the delayed release of the 2021 Physician Fee Schedule/ Quality Payment Program proposed rule coupled with the ongoing prioritization of resources dealing with the COVID-19 PHE made this a particularly challenging timeframe within which to provide detailed comments.

ACP additionally asks CMS to consider COVID-19 and other public health emergencies such as the California wildfires when considering proposed implementation timelines, risk-adjustment, and hardship exception methodologies for these and other new cost measures. The College urges CMS to build into measure methodologies sufficient exceptions and considerations for these types of wide scale disruptions and deviations from "normal" care delivery and cost patterns that operate outside clinician and practice control.

In Conclusion

ACP appreciates this opportunity to provide feedback. We welcome further opportunities to comment on these Wave 3 episode-based cost measures, as well as future cost measure development, including potential new, targeted cost metrics for incorporation into the impending MIPS Value Pathway. Please contact Suzanne Joy, Senior Associate, Regulatory Affairs, at sjoy@acponline.org or (202) 261-4553 with any comments or questions regarding the content of this letter.

Sincerely,

Ryan D. Mire, MD, FACP
Chair, Medical Practice and Quality Committee
American College of Physicians