April 24, 2017

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 314G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: Episode-Based Cost Measure Development for the Quality Payment Program

Dear Administrator Verma:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Centers for Medicare and Medicaid Services' (CMS) request for information on Episode-Based Cost Measure Development for the Quality Payment Program (QPP) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 148,000 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 from health to complex illness.

Delay in Implementation

The College urges CMS to delay implementation of the episode-based cost measures in the Cost Performance Category until the new system has had sufficient time for development and testing/refinement, followed by extensive education of clinicians on the new system and how it will impact their QPP score. The draft episode groups are still in the development process and are not yet ready for testing. Implementing the episode-based cost measures before they are ready and fully vetted, especially if they are weighted in the composite performance score, may unnecessarily result in a negative impact the performance scores of some clinicians without achieving the intended goal of aligning cost and quality with the clinician providing the care, and it will cause confusion among clinicians who are just starting the process of learning the new system under QPP. The College also urges CMS to ensure that the implementation of these categories and codes is carried out in a manner that fully considers and minimizes the impact of reporting burden on the participating clinicians and that has appropriate flexibility to

allow for learning and improvement in the approach by both the Agency and the clinicians. It is a certainty that the initial implementation of these categories and codes will identify necessary areas of improvement in terms of the category definitions, the methodology by which they are submitted, how they are used to attribute cost and patient outcomes to physicians and other clinicians, and potentially other unintended and unexpected impacts—and it is critical that clinicians not be unfairly penalized as this learning process gets underway.

Given the need for a delay until proper development, testing, refinement, and education on the episode-based cost measures has occurred, ACP reiterates its comment from the MACRA final rule that CMS zero out the cost performance category in the second performance year (2018) and continue to focus on the development and refinement of the new code sets to ensure that when cost is accounted for in the composite performance score, it is done in a more appropriate manner that factors in components such as patient condition and the costs associated with clinicians in the role in which they treat each patient.[1] Recognizing that a new cost measurement system needed to be developed, Congress specifically allowed flexibility in weighting of the cost performance in the first two performance periods of QPP, and CMS must use this flexibility to weight the cost category at zero to allow for further development and testing of the cost measures before they directly impact clinicians' composite performance scores.

Additionally, under Section 1848 of the Social Security Act (42 U.S.C. 1395w-4), subsection (q)(5)(F) as added by the MACRA law gives the Secretary the authority to assign different scoring weights (including a weight of zero) in any year if there are not sufficient measures and activities applicable and available to each type of eligible clinician involved. The College further recommends that CMS consider using this authority to reweight performance categories in the third performance period and subsequent years to reduce the weight of the Cost Performance Category to zero until the pilot referenced below has been conducted; the Agency has had time to review the results and make modifications to the codes and measures; and clinicians have had thorough education on the cost measures, any reporting requirements for new categories and code sets, and the impact these will have on their performance. As recommended in ACP's recent position paper, *Putting Patients First by Reducing Excessive Administrative Tasks in Health Care*,[2] CMS must also make every attempt to minimize any reporting or administrative burden on clinicians as it develops and implements the new episode-based cost measures. The paper outlines a cohesive framework for analyzing new and existing administrative tasks through several lenses to better understand any given administrative task and the potential impact of the task on practicing clinicians. This framework provides the foundation for a set of detailed policy recommendations aimed at various stakeholders, including regulatory agencies, to reduce excessive administrative tasks and requirements that are deemed unnecessary and burdensome.

[1] https://www.acponline.org/acp_policy/letters/avp_comment_letter_to_cms_on_macra_final_rule_2016.pdf
[2] http://annals.org/aim/article/2614079/putting-patients-first-reducing-administrative-tasks-health-care-position-paper

Episode Groups Pilot Program

In order to test the system prior to implementation, ACP recommends that CMS conduct a voluntary pilot program on episode-based cost measures once an operational set of episode groups and subgroups is fully ready for testing, no earlier than in 2018, that includes a representative sample of practice types, sites, geographic regions, etc. Clinicians who volunteer to test the episode-based cost measures, which would also incorporate CMS' proposed patient condition groups and patient relationship categories, would receive feedback reports on the cost measures but it would not be counted toward their composite performance score in the Merit-based Incentive Payment System (MIPS). Additionally, clinicians would receive full credit within the Improvement Activities Performance Category for participating in the pilot.

The pilot would provide the opportunity for CMS to collect and review data over the course of a year (or multiple years) to help further answer some of the outstanding questions for how to best develop and implement these episode-based cost measures without inappropriately penalizing physicians. The outstanding questions of particular interest to ACP include approaches to developing single episode groups for chronic conditions; duration of the episode group and potential overlap; and risk-adjustment methodology – our initial thoughts on these concepts are described in greater detail below.

Chronic Condition Episode Groups

The Agency requested comments on the approach of a single episode group for outpatient chronic care with adjustment for comorbidities and demographics of the population served by the clinician. The College would favor this approach. A single episode group for outpatient chronic care could be constructed as a "Chronic Condition Episode Group" for patients with at least two or more chronic conditions as defined by CMS. This would allow for flexibility in treating patients that may have numerous chronic conditions. At one visit, the primary clinician may be attending to three chronic conditions for 80 percent of the time and effort and attending to the other chronic conditions for 20 percent of the time and effort. The next visit may be entirely different. For example, a primary clinician may see a patient on a particular day for diabetes mellitus (DM), congestive heart failure (CHF), chronic kidney disease (CKD), atrial fibrillation (Afib), hypertension (HTN), and hyperlipidemia. The next time the clinician sees that patient, she may see him for DM and CHF, and at yet another visit may address mainly CHF but the patient also has an acute problem of back pain. The single "Chronic Condition Episode Group" for patients with at least two or more chronic conditions would capture all the combinations of chronic conditions seen and treated by the primary clinician. The duration of the episode group could span between three to six months to a full year, whatever is deemed adequate to capture the typical episode of care for patients with two or more chronic diseases.

The second part of the single episode group for outpatient chronic care would be the "adjustment for comorbidities." International Classification of Diseases (ICD)-10 diagnosis coding could be used to address "comorbidities" that increase severity and complexity of the

visit. This approach would require more accurate staging of patients through the course of their disease. Greater granularity and specificity of the ICD-10 diagnosis coding would distinguish the patient with CHF or CKD from among other conditions that are in an advanced stage (and more complicated, costly, and time consuming) from the patient in an early stage. This process would further help identify the primary clinician's contribution to the patient in a global surgical period who has a medical complication or exacerbation (e.g. pneumonia, CHF, DM out of control, renal failure, etc.) of the primary diagnosis for the visit. Additionally, this process could lead to better aggregation/disaggregation of costs with overlapping episodes. **In order to accurately capture the many chronic conditions a patient may have, ACP recommends CMS ensure that all ICD-10 codes reported on claims forms (up to 12) are recognized.**

The College believes this approach for a single episode group for chronic conditions could prove beneficial to providing flexibility without overly burdening clinicians with additional administrative responsibilities. Moreover, the use of ICD-10 diagnosis coding to provide more granularity and specificity for each chronic condition will align with the proposed use of the CMS-Hierarchical Condition Categories (HCC) risk-adjustment model discussed in greater detail in the next section.

Cost Measure Development – Risk Adjustment and Unintended Consequences of Using Cost Measures in MIPS

When risk adjusting episode groups to construct cost measures the College believes that using an already established risk-adjustment model, such as the CMS-HCC methodology used in the Medicare Advantage (MA) program, is logical and promotes alignment across the different Medicare programs. ACP recommends that the Agency require uniform coding requirements for any HCC risk-adjustment to ensure that HCC Model Categories are consistent across all plans and programs so that the episode of care is clinically homogenous for the entire beneficiary population. Anecdotally, it is believed that different MA plans use varying HCCs based on the benefits the plan provides and their specific beneficiary population. As the health care system evolves to one based on value, this uniformity will help to further align the Medicare programs, promote transparency among health plans, and lessen the administrative burden for participating physicians.

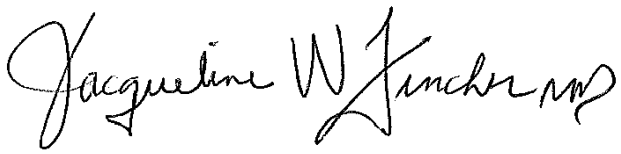
The Agency also requested feedback on whether the risk-adjustment model should be concurrent or prospective and the amount of patient data required for the risk adjustment model. **The College believes that using a prospective risk-adjustment model with a full year of patient data, as done in the MA program, is an appropriate approach in developing cost measures for episode groups.**

To further enhance the CMS-HCC risk adjustment methodology and address some unintended consequences of using cost measures in MIPS, the College recommends that CMS require the patients' socioeconomic status be considered to avoid creating a disincentive to take on more difficult, disadvantaged populations. It is important that physicians whose patient mix may be more severely ill not be disadvantaged by their resource use measures. CMS has begun to

address this within the MA program risk-adjustment methodology to account for beneficiaries who are eligible for both Medicaid and Medicare, but further incorporation of social determinants of health is necessary. Creating a disadvantage to taking on the more severely ill, medically complicated patients through inadequate risk adjustment methodology will also have a direct negative impact on patients and their families/caregivers in terms of access to appropriate, timely, quality care that is best suited for their unique needs. While socioeconomic status has been clearly linked to morbidity and mortality, the mechanisms responsible for the association may not be as well understood. Only focusing on health behavior is potentially problematic, if this behavior is viewed simply as a lifestyle choice. Episode groups must also promote access to the resources needed to engage in health-promoting behavior.

The College greatly appreciates the opportunity to submit our comments on episode groups in response to the questions raised by CMS. If you have any questions regarding this letter, please contact Brian Outland, Senior Associate, Health Policy and Regulatory Affairs at boutland@acponline.org.

Sincerely,



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