



May 24, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: Development and Reevaluation of Outpatient Outcome Measures for the Merit-based Incentive Payment System (MIPS)

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) MIPS outpatient outcome measure for hospital admission rates for patients with multiple chronic conditions. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 154,000 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.

We appreciate the attention to monitoring care coordination and clinical outcomes for patients suffering from multiple chronic conditions. As the measure methodology report notes, these are some of the most clinically complex patients and represent an opportunity to improve care management for better health outcomes, fewer complications, and reduced admissions, which all can lead to reduced spending. As you know, primary care physicians and other internal medicine specialists play an important role in the management of patients with chronic conditions, particularly those with overlapping conditions, and stand to be greatly impacted by this new measure.

We appreciate CMS incorporating stakeholder feedback by relying on recommendations from the National Quality Forum (NQF) and making a concerted shift towards outcomes measures, as recommended by ACP. With any measure used to evaluate quality or cost of care delivery, the accuracy of data collected is paramount, particularly when used to impact physician payments. ACP continues to underscore that all MIPS quality and utilization measures should meet strict, consistent criteria for reliability; clinical accuracy; and be proven to meaningfully contribute to achieving better quality outcomes, lower costs, or both. Moreover, we reiterate our concern that rolling out measures before they are ready can lead to adverse consequences on practices and more importantly, patients. If patient attribution and risk adjustment methodologies are not meticulously refined, physicians could be

inadvertently penalized for treating older, sicker, or otherwise more complex patients, potentially exacerbating access issues for already vulnerable patient populations.

There are ways to mitigate these concerns. As consistent with previous ACP recommendations, CMS should ensure all quality and cost measures are independently assessed and approved by a third party multi-stakeholder organization, including but not limited to ACP's own Performance Measurement Committee (PMC), the NQF, and the Measure Applications Partnership (MAP). Moreover, implementing measures on an informational basis, as is currently done for the Medicare Shared Savings Program for the first two years for all new or significantly modified measures, would enable CMS to collect more data to ensure the accuracy and validity of the measures before physician payments are at stake, as well as provide clinicians with a period of time to educate and familiarize themselves with new measures.

We agree with CMS that managing care for patients with chronic conditions is an important area for future study and should be an area of focus when it comes to improving patient outcomes and minimizing complications and thus achieving cost savings. However, we have several specific concerns related to statistical reliability, risk-adjustment, patient attribution, and actionability of the measure as described, particularly when applied at the individual clinician level. We explain our reservations, along with several recommendations for improving the measure, in more detail below.

Statistical Reliability

Though the report notes that the validity of the measure will be examined following public comment, it does not yet provide validity testing beyond input from the technical expert panel. CMS should re-solicit stakeholder feedback following a subsequent, more thorough evaluation of the measure's reliability. As noted earlier, CMS should also not proceed with this measure, or any other, until it is confirmed clinically and methodically valid by ACP's PMC, the NQF, the MAP, or a combination of the three.

CMS sets a minimum reliability of 0.5 and does not provide justification for this selection. ACP has repeatedly advocated that CMS set a consistent minimum reliability threshold of 0.75 for all MIPS quality, utilization, and cost measures, which is considered the minimum for "average" reliability by statisticians.¹ Notably, none of the minimum volumes listed in Table 11 would meet this standard. However, a volume of 62 would meet a minimum reliability of 0.7 and would still include approximately 82% of patients and admissions. **We urge CMS to adopt a minimum reliability value of 0.75 across all MIPS measure and to adopt a minimum volume for this measure that would meet this standard. CMS should not evaluate physicians and base their payments on measures that do not meet reasonable standards of reliability.**

Risk Adjustment

ACP appreciates CMS' proposal to include social risk factors in this model, including the Agency for Healthcare Research and Quality's SES index and specialist density. A growing body of evidence supports the important impact social risk factors have on patient outcomes.^{2,3} ACP published a [position paper](#) discussing the importance of addressing social determinants of health, as well as several policy recommendations. However, while ACP understands that CMS removed the primary care physician density and rurality variables due to a lack of statistical relevance, it is unclear why the social risk

¹ Koo, Terry K., and Mae Y. Li. "A Guideline of Selecting and Reporting Intraclass Correlation Coefficients for Reliability Research." *Journal of Chiropractic Medicine* 15, no. 2 (June 2016): 155-63. doi:10.1016/j.jcm.2016.02.012.

² https://www.who.int/social_determinants/en/

³ <https://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-questions-and-answers>

variables were tested after the clinical variables. We have concerns this may have impacted the integrity of the analysis of the social risk variables. Clinicians serving a disproportionately high amount of low socioeconomic status (SES) patients tend to perform worse than the national rate compared with clinicians serving fewer low SES patients.⁴ Therefore, implementing this measure without making these adjustments could place clinicians practicing in safety-net systems at risk for negative consequences and impact access for already vulnerable patient populations. **ACP recommends CMS remodel risk adjustment to include any social risk factors raised in this comment period and make these results available to the public before finalizing the measure.** Moreover, we urge CMS to include all variables, including social risk variables, at once, rather than modeling the social risk variables only after the clinical risk variables.

While we appreciate CMS' concerns that dual Medicare-Medicaid eligibility status is accounted for in MIPS via the complex patient bonus and including it could allow for higher admission rates for these patients and mask quality differences across clinicians, we fear that not risk adjusting for dual eligibility status could have more damaging consequences by penalizing the clinicians who treat at-risk patient populations, and potentially lead to worsened access issues for these already vulnerable patients. **For these reasons, we urge CMS to include Medicare-Medicaid dual eligibility status in the risk adjustment methodology for this measure.**

Aligning the risk-adjustment model with more robust methods for statistical analyses that consider all factors that are independently and significantly associated with outcomes across specialties and conditions (e.g., the Society for Thoracic Surgeons' Adult Cardiac Surgery Risk Model) could help to improve the accuracy of risk adjustment and avoid potential unintended consequences on patient access or adverse scoring for clinicians who treat at-risk patient populations.

Patient Attribution

Collaboration between patients and their primary care, specialty, and subspecialty practices is critical to delivering high quality, patient centered care, particularly for managing patients with multiple chronic conditions. ACP has developed a set of [core principles](#) for the patient and family role in their own care, as well as the [medical neighbor concept](#) centered on the notion of consistent communication, collaboration and coordination between a patient's care team consisting of both primary care and specialty clinicians. While the primary care physician often serves in the "quarterback" role, as the measure methodology report acknowledges, specialty and subspecialty internists frequently play an important and active role in care management, particularly for patients with chronic conditions. These roles may ebb and flow over time as patient needs change. Accordingly, ACP generally supports an attribution methodology that is deferential to primary care physicians, but also shares responsibility with specialists when they play a dominant role in caring for a patient over a period of time. While we understand they are still under development, **ACP supports the use of patient relationship codes as the preferred methodology for patients to proactively identify the clinicians who are responsible for their care for purposes of this measure, as well as others.** This supports patient-centered care and most effectively captures the nuanced, dynamic and changing model of shared care management between patients and their team of primary care physicians, specialist(s), and/or subspecialist(s). It would also avert many of the adverse consequences that can come with claims-based attribution identified below.

⁴ Lewis VA, Frazee T, Fisher ES, Shortell SM, Colla CH. ACOs Serving High Proportions Of Racial And Ethnic Minorities Lag In Quality Performance. *Health Aff (Millwood)*. 2017;36(1):57–66. doi:10.1377/hlthaff.2016.0626

ACP recommends prospective patient attribution so that practices are aware of the patients for which they are responsible for managing their care. This would both help to improve their ability to meaningfully influence outcomes for these patients and will improve transparency with regards to patient attribution for clinicians.

In general, we support attribution based on the number of visits, as opposed to charges, because it is a more accurate indicator of which clinician is primarily responsible for managing a patient's care management. Charges can more easily be skewed by a single expensive qualifying visit.

We support CMS being responsive to past concerns raised by ACP by not attributing admissions for which clinicians have a limited ability to influence outcomes. Clinicians should be evaluated for the patient outcomes they have an ability to influence, but holding clinicians accountable for admissions that they have a limited ability to impact only hurts measurement accuracy. **We advise CMS to consider specific indicators for admission directly related to the index admission diagnosis when attributing hospital visits for purposes of this measure.** The reasons for admission are variable and may be unrelated to the condition for which the clinician is managing care.

We caution policymakers that attributing hospital admissions to individual clinicians can be technically challenging because it is difficult to determine the relative influence that an individual clinician has on a patient's admission. Hospital admissions are influenced not only by the actions of one singular clinician, but increasingly by the actions of multiple clinicians working collaboratively as part of a care team to better serve patient needs. ACP supports this approach and has developed [key principles](#) for clinical care teams, including calling for reimbursement systems to encourage and incentivize clinical care teams. Accordingly, summary outcomes measures like this one are often more reflective of and accurate at the facility level. While the report cites evidence to demonstrate the efficacy of the measure at the level of Accountable Care Organizations, it does not provide evidence to justify efficacy at the level of the individual clinician, nor does it provide evidence that the measure is reliable at the Tax Identification Number (TIN)/National Provider Identifier (NPI) level, only the TIN level. Without reviewing the data on individual clinicians, we cannot be confident that the benefits of the measure facilitating progress toward achieving quality outcomes outweigh the potential for unintended negative consequences to patients and clinicians. **CMS should not move forward with evaluating this measure at the TIN/NPI level unless it can demonstrate validity and reliability at the individual clinician level, which for the reasons we outlined, may prove challenging.**

CMS could allow for a period of voluntary reporting with safe harbors for clinicians who voluntarily elect to test this measure for application at the level of the individual clinician. During this period, clinicians would receive regular feedback but would not have payments adversely impacted by their performance or trial on the measure. In the interim, CMS should evaluate the measure at the TIN level and if a clinician chooses to report as an individual, that group score could be applied to the TIN/NPI for purposes of assessing the MIPS composite score.

The attribution algorithm chosen was entitled "Alternative Visit-Based Attribution Algorithm with 2-Visit Minimum Threshold." However, under "key features" CMS notes that in the event of **one** primary care physician visit, assignment stays with the primary care physician if no specialists visits," seemingly contradicting the two-visit minimum, which was intended to "identify the clinician most responsible for patient care." This attribution model could easily result in incorrect assignment of responsibility to a clinician who is not primarily responsible for the patient's overall care. For example, hospitalists performing surgical interventions performing pre-operation and post-operation visits could trigger attribution and have higher admission rates when compared to other clinicians. One of the main

criticisms of summary of care measures, such as the Total Per Capita Cost of Care (TPCC) measure, has been that they inappropriately attribute responsibility for outcomes or costs to a clinician based on a single service, which can be easily skewed and fails to establish a consistent clinician patient relationship. CMS appeared to be recognizing the importance of establishing a pattern of care in its redevelopment of the TPCC measure in which it would require an associated primary care service or related follow up E&M service. We urge CMS not to move backwards by establishing a one-visit minimum for this measure, particularly when the intent is to establish which clinician is responsible for managing a complex patient's ongoing care. Establishing a one-visit threshold will only diminish the accuracy of the measure by diluting it with physicians who see patients only once in a performance year for an annual checkup or any other applicable reason, which can hardly be considered active disease management.

ACP strongly urges CMS to establish a visit minimum of no less than two visits, ideally three or four visits. A three-visit minimum would help to exclude hospitalists or other clinicians who perform simple pre-procedure and post-procedure work and are not actually responsible for the ongoing care management of a patient. A four-visit minimum would represent quarterly visits with the patient, a strong litmus test of responsibility for a patient's ongoing disease management. We also recommend CMS closely monitor the impact that this measure would have on hospitalists specifically.

Should CMS adopt our recommendations to establish a two-visit minimum and assess the measure at the TIN-level, which we feel is the only way to capture the data CMS intends while maintaining reliability and evidence base, we would recommend CMS adopt its alternative TIN-level assignment methodology, which would entail assigning every visit to a TIN, as opposed to NPI. This way, practices would meet the case minimum even if two different clinicians under the same TIN performed a relevant service, as is often the case in team-based care.

In general, we would also like to express concern over the variation in attribution methodologies across MIPS quality and cost measures, which contribute to the unnecessary complexity of the program.

Actionability

It is unclear whether implementation will produce actionable information for individual clinicians to drive meaningful improvement in patient care. **Stratifying and comparing the results by diagnosis related groups (DRGs) could help to mitigate this concern by listing admission rates per chronic condition and their associated index diagnosis.** This data can also provide insights into which care management interventions have been most effective in changing admission rates year-over-year.

As noted earlier, the usefulness of the measure is further limited by retrospective attribution. If clinicians are unaware of which patients they are responsible for over the course of a performance period, they have a more limited ability to drive improvements than if the patients were prospectively assigned and they were confident about the patient population they were responsible for managing.

As ACP has noted in past comments, the lack of timeliness of MIPS data is also of major concern to the utility of the data and its ability to drive improvement in patient quality of care and outcomes. These same concerns extend to this measure. MIPS performance feedback is not available until over a year after the applicable visit. This can hardly be considered a useful way to drive quality improvement. **ACP reiterates our past recommendation to provide more frequent feedback for all MIPS measures in the form of quarterly performance reports at a minimum, ideally working up to real-time claims data**

available at the point of care. This could be more easily achieved if CMS established a consistent 90-day performance period across all of the MIPS performance categories.

Conclusion

ACP appreciates the opportunity to comment. More effective disease management, particularly for patients with multiple chronic conditions, is critical to improving patient care, mitigating unnecessary complications including hospital admissions, and protecting the Medicare trust funds. Primary care and specialty internists play a critical role in caring for these patients. We hope that the agency carefully considers our detailed recommendations that we feel are necessary to improving the reliability and evidence base of this measure. In summary, we recommend CMS:

- Not finalize the measure until it is independently verified by a third party organization, including but not limited to the ACP, NQF, or MAP;
- Consider implementing this measure on an informational basis to familiarize clinicians and potentially refine the measure to improve its accuracy before impacting physician payments;
- Establish a consistent minimum reliability of 0.75 across all MIPS cost and quality measures and select a corresponding case minimum;
- Refine the risk adjustment methodology particularly as it relates to social risk factors, including accounting for dual Medicare-Medicaid eligibility status;
- Finalize patient relationship codes to improve attribution for this and other MIPS measures;
- Not move forward with evaluation at the TIN/NPI level until reliability and validity at this level can be established;
- Establish a visit minimum of no fewer than two visits; and
- Provide more frequent performance feedback on this and all MIPS measures.

We understand this is the beginning of an ongoing conversation and look forward to continuing to provide feedback throughout the development of this and other MIPS quality and cost measures. Please contact Suzanne Joy by phone at 202-261-4553 or e-mail at sjoy@acponline.org if you have questions or need additional information. Thank you for considering our comments.

Sincerely,



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