



January 4, 2019

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

Dear Administrator Verma:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Clinician and Clinician Group Hospital-wide All-cause Unplanned Readmission (HWR) Measure for purposes of assessing performance in the Merit-based Incentive Payment System (MIPS). The College is the largest medical specialty organization and 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.

The College recognizes the importance of holding practices accountable for patient outcomes within their control and ensuring effective transitional care management, which is critical to improving patient outcomes. We appreciate the Centers for Medicare & Medicaid Services (CMS) being responsive to prior [concerns](#) raised by ACP and other stakeholders regarding flawed iterations of 30-day hospital readmission measures by making several improvements, particularly related to attribution and risk-adjustment. We value the Agency's ongoing commitment to soliciting stakeholder feedback throughout the development process, including conducting a technical expert panel and offering this public comment period.

However, the College firmly believes that all measures used to impact physician payments based on quality and cost performance must be appropriately attributed and risk-adjusted, evidence-based, clinically relevant, and statistically reliable and valid. We do not believe the HWR measure meets this standard and therefore we cannot support it in its current form.

Patient Attribution

ACP continues to have concerns about the appropriateness of attributing patients at the

clinician level, particularly primary care clinicians. This aligns with the primary concern voiced by respondents who disagreed that the measure was valid and useful.

The College urges CMS to prove through a robust evidence-based analysis that this measure can be evaluated at the clinician level while meeting stringent validity and reliability standards. If this cannot be proven or completed in time for implementation, we encourage CMS to evaluate this measure at the Tax Identification Number (TIN)-level and apply the resulting score to eligible clinicians wishing to be scored individually. Attributing this measure at the clinician level would result in small sample sizes that would be subject to large swings in performance and low levels of reliability and validity. The development data showed that individual clinicians had a wider range of average risk-adjusted readmission rates (RARRs) when compared to groups and were more likely to perform statistically significantly better or worse than the national observed readmission rate. Applying the measure at the TIN-level would result in a larger patient population which helps to ensure higher reliability, support team-based care and support the Center for Outcomes Research & Evaluation (CORE) team's principle goal to align closely with hospital-level measures, which are measured at the facility level. CMS could also help to mitigate low-reliability at both levels by increasing the case minimum threshold. Attributing admissions to primary care clinicians based on the index admission rather than the readmission is an improvement over past methodologies but does nothing to address the underlying concerns over the inherent validity of evaluating this type of measure at the individual clinician level.

There was no evidence provided that primary care clinicians who deliver the plurality of services in the year leading up to the initial admission have sufficient control over readmissions. All measures, especially those tied to payment, must be evidence-based and attributed to the appropriate unit of analysis e.g. where the measure addresses an outcome that is under the influence of the clinician being assessed. This is precisely why the National Quality Forum (NQF) requires as part of its [measure evaluation criteria](#) that for any outcome measure, at least one structure or process must influence the outcome and this relationship must be demonstrated through empirical evidence. While this report acknowledges that certainly primary care providers may have some influence over hospital admissions or readmissions, it provides little evidence to substantiate the claim that readmissions are statistically significantly influenced by the primary care services that a patient received in the year leading up to an initial admission. The CORE team acknowledges as much when it says in its report that "inpatient outcomes may be most reasonable attributed to inpatient clinicians."

Reliability

As reiterated previously, any reliability rating below a 0.75, which is [considered the minimum](#) for "good" reliability by statisticians, should be unacceptable for any quality or utilization measure. We urge a case minimum of no fewer than 100 patients, as recommended by the CORE team. To further increase reliability, we urge CMS to consider a higher case minimum such as 200 patients, which was used for a similar readmissions measure for the Value-Based Payment Modifier. Finalizing the policies as proposed would lead to unreliable measures, particularly for groups that are small and/or serving rural communities. Measure validity and

reliability should never be sacrificed in the interest of adopting more measures or applying measures to more clinicians. CMS should independently set rigorous, consistent standards for reliability and validity against which all future measures will be evaluated.

Risk-Adjustment

Additional refinements are needed to the risk adjustment methodology to evaluate physicians accurately and mitigate a host of potential unintended consequences, including patient cherry-picking and access to care. In addition to adjusting for case mix, CMS should consider accounting for the total number of conditions each patient has, which has been [proven](#) to impact outcomes. CMS recently finalized this as part of the risk adjustment mechanism for Medicare Advantage contracts in the final [2019 Medicare Advantage Rate Notice and Call Letter](#). This is a positive change that will better account for the expertise and risk inherent to caring for more complex patients. We support this policy for Medicare Advantage beneficiaries and urge CMS to extend it to traditional Medicare beneficiaries.

By not properly accounting for a host of geographic and social risk factors, CMS risks inappropriately penalizing physicians who treat some of the most vulnerable patient populations, which could further restrict access for these already at-risk patients. As ACP has stressed in previous [research](#), there is a huge chasm in current quality and cost risk adjustment methodologies for geographic and social risk factors that have been proven to significantly impact quality and cost outcomes, including distance from the nearest hospital or specialist or socioeconomic status. The shortsighted explanation provided in the report that the association between socioeconomic status and health outcomes “is due, in part, to differences in the quality of care that groups of patients with varying socioeconomic status receive” does not begin to account for the host of confounding variables beyond a physician’s control, including access to transportation to make medical appointments, ability to afford critical medications, etc. It is paramount that CMS expediently test, study, and more adequately account for the impact that geographic and social risk factors before finalizing this or any additional measures.

Testing and Implementation

The unplanned hospital readmission measure requires further development and testing to ensure its validity and reliability, particularly in relation to primary care physicians, before it can be responsibly implemented and applied to a clinician’s MIPS score. Any measure should not be used to directly impact physician payment in any way before it can be proven to be a predictable, reliable and accurate indicator of true quality and cost performance and does not unfairly penalize physicians for outcomes outside of their control.

Once this measure has been revised to meet rigorous validity and evidence-based standards, we encourage CMS to allow for a period of voluntary reporting during which clinicians would receive feedback related to their performance on this measure, but would not have their MIPS scores adversely impacted. This would allow an opportunity for physicians to familiarize themselves with the measure and for CMS to gather more data to affirm the accuracy of this measure and further refine it if necessary before it impacts physician payment. Given the

current reporting, feedback, and payment adjustment cycle occurs over a two-year timespan, we recommend the measure be available for testing but not impact payment for at least two years to allow for at least one round of performance feedback before clinicians are evaluated.

CMS should not move forward with finalizing any new utilization measures until they have the full approval of both the National Quality Forum (NQF) and Measure Applications Partnership (MAP). These bodies provide critical stakeholder input and are necessary to a sound, transparent measure development process that yields clinically valid and statistically reliable measures. Moving forward without their approval on this or any measure jeopardizes transparency and legitimacy and could lead to inaccurate cost and quality measurement.

We reiterate that CMS should not increase the weight of the Cost Category or add any additional measures without addressing the concerns raised in this letter related proper risk adjustment, patient attribution, and reliability and accuracy. While we appreciate CMS' point that they are required under current statute to increase the weight of the Cost Category to 30% by performance year 2022, CMS should not sacrifice accurate cost measurement for the sake of meeting a timeline that is years off and could change. Congress could revise the timeline to afford CMS additional flexibility just as it did with the Bipartisan Budget Act. ACP shares the Agency's goal to reward clinicians who are delivering high-quality, efficient care, but reminds CMS that this only works with accurate cost and quality measurement. Otherwise, a host of unintended consequences could ensue, such as clinicians being penalized for treating sicker or older patients. The Agency should instead focus on updating these measures with all due speed and only after they are confident in the methodology and reliability for every cost measure should they look to increase the weight of the Cost Category.

Conclusion

It is our hope that based on the concerns raised in this letter, CMS will continue to study, test, and refine the HWR measure until it is proven to be evidence-based, reliable, and valid before it is used to impact physician payments. Above all else, CMS should carefully consider the negative implications that unreliable scores and feedback could have on patient outcomes and access to care. We appreciate the opportunity to offer feedback and your consideration of these comments. The College looks forward to continuing to support CMS in its work to continuously improve and refine the accuracy of cost and quality measurement to ensure physicians are being appropriately evaluated and held accountable for their performance so patients can continue to receive the highest quality care. Please contact Suzanne Joy at 202.261.4553 or sjoy@acponline.org if you have any questions or need additional information.

Sincerely,



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American College of Physicians