PUBLIC COMMENT SUMMARY REPORT

Project Title

Development and Reevaluation of Outpatient Outcome Measures for the Merit-based Incentive Payment System

Dates

The Call for Public Comment ran from April 24, 2019 to May 24, 2019. This Public Comment Summary Report was prepared in June 2019.

Project Overview

The Centers for Medicare & Medicaid Services (CMS) contracted with Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation (CORE) to develop outcome measures for ambulatory care clinicians for the Merit-based Incentive Payment System (MIPS). The measures will be used to assess the quality of care provided by clinicians or clinician groups who are eligible to participate in MIPS and report their quality under a common Taxpayer Identification Number (TIN). The contract name is Measure & Instrument Development and Support (MIDS): Development, Reevaluation, and Implementation of Outpatient Outcome/Efficiency Measures. The contract number is HHSM-75FCMC18D0042.

As part of this project, CORE developed a measure of acute hospital admissions for patients with multiple chronic conditions (MCCs). Specifically, CORE adapted for MIPS a measure of acute, unplanned admissions for MCC patients that CMS currently reports for Medicare Accountable Care Organizations. The re-specified measure for MIPS will assess each TIN's admission rate relative to that of other TINs with similar patients. The quality measure uses patient characteristics and outcomes documented on routinely submitted Medicare claims; therefore, the MIPS eligible clinicians or clinician groups whose performance will be assessed by the quality measure will not need to submit any additional data directly to CMS.

As part of its measure development process, CMS posted the measure for public comment. This report summarizes the comments received and presents CMS' responses.

Project Objectives

The primary goal of public comment was to gather expert and stakeholder input to inform quality measure development and reevaluation for patients with acute or chronic conditions. CMS will use the measure to evaluate the quality of care provided by MIPS eligible clinicians.

Information About the Comments Received

Public comments were solicited through:

- Email notifications to:
    - CMS listservs.
    - CORE's stakeholders and stakeholder organization listservs, including:
        - Business and consumer advocacy organizations.
        - Condition-related registries.
        - Electronic Health Record vendors.
        - Healthcare quality-focused organizations.

        - Insurance and purchaser organizations.
        - National professional associations and clinician societies.
        - Patient advocacy groups and patient safety organizations.
        - Quality improvement and measurement organizations.
        - Research organizations.
        - State medical societies.
        - Topic knowledge-related organizations.
    - The project's national Technical Expert Panel (TEP).
    - TEPs and Clinician Committees for related MIPS cost or quality measures under development not covered by this project.

- Presentation to clinicians and practice managers in the voluntary Clinician Champions Program to elicit feedback.

- Presentation at national conferences (CMS Quality Conference, Academy Health).

- Web posts on the CMS Public Comment website.

In total, 12 commenters provided input on the MCC measure. All 12 commenters were organizations.

- Five of the 12 commenters were professional societies representing broader groups of clinicians.
    1. American College of Physicians (ACP)
    2. American Geriatrics Society (AGS)
    3. American Medical Association (AMA)
    4. Association of American Medical Colleges (AAMC)
    5. Physician Consortium for Physician Improvement (PCPI)

- Seven of the 12 commenters were medical specialty societies representing a focused group of clinicians.
    1. American Academy of Neurology (AAN)
    2. American Society of Clinical Oncology (ASCO)
    3. American Society of Hematology (ASH)
    4. American Society for Radiation Oncology (ASTRO)
    5. Emergency Nurses Association (ENA)
    6. Endocrine Society
    7. Heart Failure Society of America (HFSA)

Stakeholder Comments – General Comments

Two commenters agreed care for patients with chronic conditions is an important focus area for improving patient outcomes.

Response: We thank the commenters for their support. The MCC measure directly applies to the CMS' Meaningful Measure area of management of chronic conditions and addresses the healthcare priority of promoting effective prevention and treatment of chronic disease.

Three commenters appreciated CMS' incorporation of stakeholder feedback in measure development. Of these, one commenter specifically appreciated CMS' extension of the comment period and another commenter commended the TEP's composition as representative.

Response: We appreciate the commenters' acknowledgements. As part of its measure development process, CMS asks measure developers to convene a national and multi-stakeholder TEP to

contribute direction and thoughtful feedback as well as host an open public comment period to broaden input on the measure.

Two commenters took issue with re-specifying a measure initially designed to assess care delivered by Accountable Care Organizations (ACOs) (i.e., providers who provide coordinated care for patients) for MIPS clinicians.

Response: CMS appreciate the comments. CMS chose to re-specify a measure initially designed to assess care delivered by ACOs (ACO-38/NQF #2888) for MIPS clinicians in an effort to promote alignment of quality improvement efforts and harmonization of measures across CMS programs as appropriate. CMS agrees with the commenters that there are key differences between the ACO and MIPS settings; as discussed in the measure's Methodology Report posted for public comment in April 2019, CMS took these into account during re-specification and has adapted the approaches to the measure cohort, outcome and risk adjustment to reflect that MIPS clinicians often have a more limited ability to influence the factors that affect the outcome of unplanned admissions than ACOs.

Stakeholder Comments – Measure Specific

Attribution

Five commenters expressed support for the approach to attribution. Of these:

- One commenter stated the algorithm is reasonable and would lead to accurate attribution of patients to a responsible clinician.
- Two commenters supported the use of visits versus charges in driving attribution.
- One commenter stated the approach will allow the measure to be as accurate as possible and capture the data from the most relevant patient-clinician interaction. However, the commenter provided further input on the limited actionability due to use of retrospective attribution.
- One commenter noted the attribution options selected are the most reasonable. The commenter provided further input on the limited actionability due to use of retrospective attribution and lack of alignment in attribution across MIPS measures.

Response: We thank the commenters for their support of our approach to patient attribution, which begins with identifying the clinician most responsible for a patient's care based on preponderance of visits. Some commenters expressed concerns about the use retrospective attribution and lack of alignment of attribution approach with other MIPS measures; responses to these concerns are provided below.

Overall, five commenters did not support the use of retrospective attribution as it limits the measure's usefulness for driving quality improvement. Clinicians would be unaware of which patients they are responsible for over the course of the performance period, and this would limit their abilities to drive improvement. Of the five commenters, two suggested CMS develop a prospective attribution model, and one suggested CMS make available the list of patients in the cohort upon request of a clinician.

Response: Currently, all risk-adjusted MIPS outcome measures, such as the MIPS hospital-wide readmission measure, use retrospective attribution. We appreciate the comments and suggestions, and CMS will explore approaches to prospective attribution as the Patient Relationship Categories and Codes become routinely used and recorded in Medicare claims data.

Four commenters suggested refinements or alternatives to the measure's attribution algorithm. Of these:

- One commenter recommended that the algorithm have a visit minimum of no fewer than two visits. The commenter suggested using a three-visit minimum to avoid assignment to hospitalists or other clinicians who provide pre/post-procedure services or a four-visit minimum to capture quarterly patient visits representative of ongoing disease management. This commenter also recommended CMS monitor the impact of this measure on hospitalists.

  Response: For over 95% of assigned patients, there were at least two visits with the assigned clinician. A small proportion of patients (4.7%) had one visit with one primary care provider (PCP) only. In such cases, to promote accountability, we assigned the patient to that PCP since she/he was the only clinician responsible for the patient's care. We vetted both alternative minimum visit thresholds as well as criteria for selecting among alternative approaches to attribution with the TEP. One criterion for attribution selection was minimizing the number of unassigned patients, which increased substantially with a higher minimum visit threshold. Thus, the TEP supported the general approach of requiring a two-visit minimum, except in the small proportion of cases in which only one PCP was seen once. To clarify, the MIPS MCC admission measure is designed to assess the quality of ambulatory care for patients with MCCs; the measure does not include hospitalists.

- All four commenters recommended or asked whether the attribution algorithm consider the reason for admission. The commenters offered different variations on how the algorithm could incorporate the reason.
  - One commenter recommended the reason for admission be the primary factor for assignment. While this commenter had noted CMS identified most of the relevant clinicians, the commenter noted the quarterbacking clinician may not always be responsible for the disease that caused the admission.
  - One commenter suggested an International Classification of Diseases (ICD) code relevant to the MCCs qualifying a patient for the measure trigger attribution.
  - One commenter suggested using indicators related to the index admission diagnosis.
  - One commenter asked whether the diagnosis for the acute admission could be used in attribution. The commenter provided the following scenarios: "If a patient was seen twice by a PCP and twice by a cardiologist, the patient would be attributed to the PCP. If this patient has a chronic obstructive pulmonary disease (COPD) admission, it would be reasonable to attribute that admission to the PCP. However, if the patient has a heart failure admission, the cardiologist should be equally responsible."

  Response: We appreciate the commenters' suggestions. However, the measure is designed to assess care for a full year regardless of the pattern of admissions (in contrast to attribution algorithms focused on episodes of care). In this context, not all patients are hospitalized, and some may be hospitalized more than once for different reasons. Hence, the first step of our TIN-level approach to attribution is to identify the clinician most responsible for a patient's care and thus for reducing the patient's risk of all measured admissions.

- Two commenters suggested attributing to multiple providers (i.e., to both PCPs and specialists). Of these, one commenter suggested CMS consider using the recently adapted MIPS HWR/ACR measure's algorithm that attributes to the discharging physician and the outpatient PCP.

Response: We note that this is a measure of outpatient care quality, and thus hospital discharging physicians are not included in the measure. The focus of the measure is on TIN-level attribution and quality measurement. CMS considered multiple attribution for this measure but decided against it given support for identifying and holding accountable the clinician who is "quarterbacking" a patient's care and because of computational challenges introduced by multiple attribution in the ambulatory setting.

- One commenter suggested using patient relationship codes though noted these codes are still under development by CMS.

Response: We appreciate the commenter's feedback and will consider possible refinements of the attribution algorithm when the measure undergoes reevaluation. CMS will explore approaches to attribution that incorporate the Patient Relationship Categories and Codes as they become routinely used and recorded in Medicare claims data.

Four commenters provided input on the underlying attribution concept of identifying and assigning responsibility to the PCP or specialist who is "quarterbacking" the care of patients with MCCs. Of these:

- Two commenters supported the concept. One of these commenters noted it imparts flexibility and will allow for meaningful measurement. The other commenter generally supported an approach that is deferential to PCPs but noted there may be instances of shared responsibility with specialists.

- Two commenters did not support the concept. One of these commenters noted while PCPs often quarterback the care of patients, more complex patients see more providers (i.e., subspecialists) that will impact their risk of admission. The second commenter, whose constituents are neurologists, further noted neurologists should not be included as a relevant specialist for attribution.

Response: We appreciate the comments and agree that there are instances where patients are seeing multiple providers who impact risk of admission. An underlying premise of our approach to attribution, which is supported by our TEP as well as clinicians and practice managers in the voluntary Clinician Champions Program, is that ideally there is an individual clinician who is taking responsibility for managing and coordinating the care of an MCC patient. In most cases, this will be a PCP. For some patients, however, there may be a "dominant" specialist who is fulfilling this role. For still others, care may be diffused or shared across multiple providers in such a way that no one dominant provider can be identified for attribution, in which case the patient is unattributed by the measure. Lack of support for including neurologists in the measure is addressed below.

Five commenters agreed with our goal of attributing patient admissions to a single provider. Three of these commenters agreed with specialists being included in the attribution.

Response: We thank the commenters for sharing their thoughts.

Seven commenters provided input on the clinician types to whom the measure should apply. Of these:

- Three commenters supported the provider types (PCPs and six specialists) included in the measure. Of these:
    - One commenter noted advanced practice nurses who are included in the measure are key stakeholders for the measure.
    - One commenter noted CMS had identified most of the clinicians who would participate in the care of the cohort-qualifying conditions.

- One commenter agreed with including PCPs and specialists when they play a dominant role in patient care.

- One commenter suggested additional specialists be included as relevant specialists. Specifically, the commenter suggested including psychiatrists, infectious disease specialists, rheumatologists, and gastroenterologists. The same commenter noted geriatricians who are included in the measure may sometimes play the role of a specialist.

- Four commenters did not support the inclusion of certain specialists. Of these:
  - One commenter did support including its constituents, neurologists, as relevant specialists for any disease but stroke/TIA. The commenter recommended CMS develop specialty-specific outcome measures to incentivize care coordination.
  - One commenter did not support including its constituents, radiation oncologists, as relevant specialists. The commenter noted patients receiving radiation therapy see the radiation oncologist many times over several weeks for consultation, treatment, and follow-up. Given the visit-based attribution assigns to a dominant specialist, the commenter believed it could assign many patients to radiation oncologists. The commenter cited a survey it conducted with its constituents on practice patterns of oncologists in the United States; only 2% of its members stated they routinely provide primary care services, and 54% said they never provide primary care services.
  - Two commenters did not support including their constituents, hematologists/oncologists, as relevant specialists because cancer or other conditions managed by hematologists/oncologists are not cohort-qualifying conditions. One of the commenters noted that without a cancer diagnosis, it is unlikely oncologists would manage the cohort-qualifying conditions.

Response: We thank the commenters for their thoughtful input. The choice of PCPs and specialists covered by the measure which was discussed extensively with and was informed by our Technical Expert Panel (TEP) as well as supported by clinicians and practice managers in the voluntary Clinician Champions Program, and acknowledge the suggestions and critiques of the other commenters.

Regarding the suggestion to include additional specialists in the measure, we do not anticipate expanding the list of covered specialists for this measure to providers (e.g., infectious disease specialists and gastroenterologists) who typically do not coordinate the care of MCC patients with two or more of the cohort-qualifying conditions. We agree with including geriatricians; CMS' definition of PCPs includes physicians practicing geriatric medicine. By treating geriatricians as PCPs, the attribution algorithm favors identifying them as the "quarterback" of patients' care when they have the preponderance of visits.

Finally, we thank the commenters for their suggestions to exclude certain specialists (i.e., neurologists and cancer specialists). Upon further consideration, we plan to continue to retain neurologists as relevant specialists. The decision to include neurologists and cancer specialists in the measure was informed by input from our TEP. Further, stroke/TIA is a cohort-qualifying condition, and it is plausible for neurologists to provide overall coordination of care for patients with MCCs including stroke/TIA. In addition, this MCC measure fulfills CMS' commitments to developing crosscutting measures applicable across clinician specialties and outcome measures for MIPS.

On the other hand, upon further consideration, we agree with removing oncologists as relevant specialists. Even though cancer is not a cohort-qualifying condition, we had included hematologists/oncologists as relevant specialists based on input from our TEP and acknowledging

that cancer care is episodic and that when a patient is actively in cancer treatment overall responsibility for his/her care is largely assumed by the cancer specialist. However, in consideration of the commenters' input, we have updated the measure to exclude patients assigned to cancer specialists as the measure is not designed to assess the quality of care provided by such providers.

Two commenters expressed concern about the lack of alignment in attribution across MIPS measures. These commenters were concerned the variation in attribution methodologies across MIPS quality and cost measures would contribute to the program's complexity, increase clinician frustration about MIPS, and increase administrative burden.

Response: We appreciate the commenters' concerns; however, based on guidance from the National Quality Forum (NQF) and input from experts and stakeholders, CMS is taking a measure-specific approach to attribution for newly developed outcome measures that is tailored to the clinicians covered by the measure and the outcome measured. CMS is balancing the sometimes competing goals of simplicity, transparency and validity, and will seek to simplify and align attribution algorithms as much as possible consistent with sound measurement.

Four commenters did not believe CORE presented enough evidence from the literature that individual clinicians can drive better quality through improved care coordination. Three of these commenters note literature is strong at the ACO and team-based levels, however.

Response: We thank the commenter for this critique and the opportunity to clarify the relevant findings in the literature. We are aware of and have integrated into the measure documentation references that more directly support the positive effect that individual providers and group practices can have on lowering patients' hospital visit rates. In addition to the previously cited studies by Kern et al. (2016) and Sommers et al. (2000), we note that Bazemore et al. (2018) found that primary care physicians with higher patient continuity-of-care scores had lower beneficiary expenditures and odds of hospitalization.[1,2,3] Similarly, O'Malley et al. (2019) found that PCPs with greater comprehensiveness scores (i.e., provided more comprehensive care) had lower beneficiary expenditures and hospitalization rates.[4] We also relied on expert and stakeholder input in reaching the conclusion that the measure score can be improved through better care quality.

Two commenters requested clarifications.

- One commenter asked who the "dominant" specialist" for a patient with multimorbidity would be if a patient, for example, saw a cardiologist six times per year and a nephrologist five times per year.

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[1] Sommers LS, Marton KI, Barbaccia JC, Randolph J. Physician, nurse, and social worker collaboration in primary care for chronically ill seniors. *Arch Intern Med.* 2000;160(12):1825-1833.

[2] Kern LM, Edwards A, Kaushal R. The Patient-Centered Medical Home and Associations With Health Care Quality and Utilization: A 5-Year Cohort Study The Patient-Centered Medical Home and Health Care Quality and Utilization. *Annals of Internal Medicine.* 2016;164(6):395-405.

[3] Bazemore A, Petterson S, Peterson LE, Bruno R, Chung Y, Phillips RL. Higher primary care physician continuity is associated with lower costs and hospitalizations. *The Annals of Family Medicine.* 2018;16(6):492-497.

[4] O'Malley AS, Rich EC, Shang L, et al. New approaches to measuring the comprehensiveness of primary care physicians. *Health Services Research.* 2019;54(2):356-366.

Response: Based on the scenario above, the patient would be unassigned because no one specialist was dominant (i.e., no specialist was seen two or more times than other specialists), unless there is evidence that the patient saw a PCP at least twice, in which case the patient would be assigned to the PCP.

- Another commenter requested CMS provide additional information on the approach and rationale for which attribution approach was used in the testing at the group level.

  Response: The focus of the measure is on TIN-level attribution and quality measurement. As a first step in attribution, we use a visit-based algorithm to identify the eligible clinician most responsible for a patient's care. Eligible clinicians then bring their assigned patients with them to the TINs that they choose to report under. To calculate the TIN's measure score, we aggregate all the TIN's providers' assigned patients.

Cohort

One commenter agreed with the inclusion of depression as a cohort-qualifying chronic condition, stating that the number of patients that present with mental health complaints to the emergency department has increased significantly.

Response: We thank the commenter for their support of the measure cohort.

One commenter suggested there should be considerations in this measure for patients with Stage D heart failure who are not on hospice and patients on inotropic therapy as these patients have underlying comorbidities and are not candidates for advanced heart failure therapy. The commenter noted it is difficult for clinicians to keep them out of the hospital.

Response: We thank the commenter for this suggestion and will consider aligning the definition and handling of heart failure in the MIPS MCC and a related MIPS heart failure admission measure currently under development. Specifically, we will explore excluding patients with all signals of advanced heart failure (e.g., left ventricular assist device [LVAD] implant, home inotropic therapy, and heart transplant) and transplant patients since thresholds for admission are very low for these patients. In addition, we will consider censoring (excluding) from the outcome admissions occurring after LVAD implant, home inotropic therapy, or heart transplant.

One commenter recommended adding cognitive and mobility late effects to the list of cohort-qualifying conditions in addition to acute stroke events because they contribute significantly to making older patients complex to treat. As an example, the commenter noted, a person with a stroke 2 years ago with residual gait impairment would be in the cohort if late effects were included.

Response: We thank the commenter for this suggestion and will consider adding cognitive and mobility late effects to broaden identifications of patients with stroke/TIA during measure reevaluation. Currently, we identify stroke/TIA patients for the measure with the CMS Chronic Conditions Data Warehouse (CCW) algorithm. The CCW algorithm identifies patients with TIA/stroke using a validated list of ICD-9 and ICD-10 diagnosis codes, which was developed after reviewing validated algorithms from literature. We agree with the commenter that patients with late effects of cerebrovascular disease are more complex to treat. We note that the measure, as specified, accordingly adjusts for these late effects (ICD-9 438.X and ICD-10 I69.X).

Outcome

One commenter supported the outcome of acute, unplanned admissions.

Response: CMS thanks the commenter for supporting the measure outcome.

One commenter supported the exclusion of admissions for hospice patients.

Response: CMS thanks the commenter for supporting the measure outcome.

Two commenters provided input on the exclusion of admissions that occur within a 10-day "buffer period" of time after discharge from a hospital, SNF, or acute rehabilitation facility. One commenter agreed with the exclusion criterion and cited a recent survey completed by its council members wherein only a small percentage of patients who were discharged saw their PCP within 30 days of discharge. The second commenter who noted their constituents treat the sickest of patients also agreed the exclusion criterion is important but recommended the buffer period be extended from 10 to at least 30 days.

Response: We thank the commenters for their support of a buffer period following discharge from a hospital, SNF, or acute rehabilitation facility. Early in the measure development process, we considered alternative lengths for the buffer period but decided on 10 days for several reasons. The 10-day buffer period is consistent with CMS' transitional care management guidance that complex patients be seen within 7 days of discharge and allows for time for care management plans to be implemented. Admissions within a shorter period of time from discharge are more likely to reflect the quality of institutional care, whereas admissions further out from discharge are more likely to reflect the quality of ambulatory care after discharge back into the community. By extending the buffer period to 30 days, we would potentially miss important admissions likely influenced the quality of care provided by MIPS-eligible clinicians in the outpatient setting. However, we acknowledge that there is no evidence to support the exact length of the buffer period; CMS reached a decision on the buffer period supported by empiric analysis and input from the TEP.

One commenter noted many factors affect admissions beyond the PCP's control and therefore admissions are often not reflective of the PCP's quality of care. The commenter suggested CMS make adjustments for hospital's admission rates per MCC (i.e., what are admission rate for COPD or heart failure exacerbations).

Response: We agree that not all admissions are preventable. The expectation is not zero admissions. Based on extensive analysis and input and deliberations by the TEP, the measure excludes from the outcome admissions that are unlikely to reflect the quality of care provided by the types of clinicians covered by the measure, such as post-surgical admissions. We appreciate the suggestion to consider admission rates for specific conditions. To clarify, clinical variables in the risk-adjustment model already adjust for the each of the MCC qualifying conditions; the coefficients for these variables reflect the relative risk of admission associated with the qualifying diagnoses after adjusting for other demographic and clinical factors. Finally, we note that CMS is developing specialty-specific measures in alignment with the Quality Payment Program Measure Development Plan.

Risk Adjustment

Five commenters responded to CMS' question about whether the measure should adjust for Medicare-Medicaid dual-eligibility status; all recommended including it in the risk model. Of these:

- Four commenters supported measure-level adjustment for dual-eligibility status although MIPS program has a "complex patient" policy adjustment that may diminish the potential unintended

consequences of not adjusting for social risk factors in this measure. Some commenters acknowledged the downsides of adjusting (i.e., masking disparities) and noted that additional social risk factors beyond dual-eligibility status may impact performance.

- One commenter recommended adjusting for dual-eligibility status to more directly address clinician-level challenges in caring for many duals, rather than adjusting for the Agency for Healthcare Research and Quality (AHRQ) Socioeconomic Status (SES) Index as proposed, stating that the Index does not capture poorer patients that live in wealthier neighborhoods.

Response: CMS thanks the commenters for their input. Given our conceptual model (described in Section 2.6.2 of the measure's Methodology Report posted for public comment in April 2019), empiric findings, and feedback we received from our national TEP, CMS has decided to adjust the measure for the AHRQ SES Index and specialist density but not for dual-eligibility status. The rationale for not adjusting for dual eligibility is:

- *The AHRQ SES Index variable already captures multiple aspects of social deprivation that can impact patients' health and health outcomes, including poverty and median household income; unemployment; education; and housing value and quality. These factors are deeply rooted in societal disparities, and MIPS providers have little influence on their effect.*
- *While dual-eligible beneficiaries are likely to have fewer available health/healthcare supports, and may also have other unmeasured social risk factors (e.g., low health literacy), CMS is not adjusting the model for dual eligibility because:*
    - *Adjusting for dual eligibility can mask disparities in care for dual-eligible beneficiaries as acknowledged by one commenter.*
    - *The marginal impact of including dual eligibility is attenuated after accounting for demographic, clinical, and frailty risk factors, as well as the AHRQ SES Index and specialist density social risk factors.*
    - *Dual-eligibility enrollment criteria vary on a state-to-state basis and may not fairly capture vulnerable patients across states.*
    - *Clinicians may have more ability to mitigate social risk associated with dual eligibility, especially if a dual-eligible beneficiary is living in a non-socially deprived community.*
    - *Not adjusting for dual eligibility is aligned with the conceptual model for the measures; the model developed with the TEP emphasizes adjusting for community not individual risk factors because patients living within very under-resourced areas pose challenges that are particularly hard for clinicians to address (e.g., lack of community services, transportation, poor housing, and/or low education).*
    - *TEP members supported including only the AHRQ SES Index and specialist density social risk factors in the model.*

Three commenters expressed concern with or questioned the approach of analyzing the effects of social risk factors after demographic/clinical factors were already added to the model, rather than assessing independent associations of social risk factors concurrently with clinical factors. Additionally, two commenters requested that CMS conduct additional testing to evaluate social risk factors, including dual-eligibility status, at the same time or prior to clinical variables.

Response: CMS' approach to evaluating the marginal effects of social risk factors after accounting for demographic and clinical risk variables is consistent with guidance issued in recent reports on

social risk factor adjustment from the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine (NASEM), because it reveals the magnitude of the marginal effect to inform policy decisions. Examining the marginal effects of these variables after adjusting for demographic, clinical, and frailty variables, best illuminates the tradeoffs inherent in adjusting.[5,6] In addition, the phased approach of evaluating demographic/clinical risk variables followed by residential/community factors and then individual measures of socioeconomic position is consistent with the conceptual framework that we developed in consultation with our TEP.

One commenter suggested CMS include any social risk factor raised in the public comment period in risk adjustment.

Response: CMS thanks the commenter for this recommendation. No other social risk factors were raised in public comment.

One commenter expressed concern with adjusting for social risk factors in a standardized way across the country, noting that the risk in rural or economically disadvantaged areas was not adequately accounted for in the measure.

Response: CMS thanks the commenter for this feedback. As presented in the measure's Methodology Report posted for public comment in April 2019, we evaluated the risk of admission for Medicare beneficiaries living in rural vs. non-rural areas of the country, and did not find a substantially higher event rate, and thus did not include it in our model. We do agree with the commenter, however, that there are many factors that contribute to complexity in patient care across the country. To account for this variability, especially for patients in economically disadvantaged areas, we adjust using the AHRQ SES Index. The AHRQ SES Index is a widely used variable that summarizes area-level measures of employment, income, education, and housing. In our team's previous work and the work of others, various aspects of income (e.g., household income, poverty rate, income inequality) and housing (e.g., value, ownership, crowding) have been examined in relation to quality measurement. Because there is no hypothesized reason specifically supporting the use of any particular neighborhood variable(s) for this measure of unplanned hospital visits, we favored the use of a composite variable that was more likely to capture relative SES across neighborhoods. CMS will conduct additional social risk factor analyses during measure reevaluation.

Three commenters supported decisions related to risk adjustment including adjusting for AHRQ SES Index and specialist density.

Response: CMS thanks the commenters for their comments.

One commenter did not support using historical data for risk adjustment because using it adjusts for patients living with cancer in a chronic phase, but not for patients with cancer in an acute phase (e.g., survivors and patients on long-term maintenance). The commenter suggested including in risk adjustment all diagnoses from the prior and current calendar years up to the second visit of the

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[5] Steinwachs DM, Stratton, K., Kwan, L. Y. Accounting for Social Risk Factors in Medicare Payment. Washington DC: 2017 by the National Academy of Sciences;2017.

[6] United States Department of Health Human Services Office of the Assistant Secretary for Planning and Evaluation. Report to Congress: social risk factors and performance under Medicare's value-based purchasing programs. 2016; https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf. Accessed June 28, 2019.

attributed provider as done in the Medicare Spending per Beneficiary and other episode-based programs, or excluding patients presenting with a new diagnosis in the current calendar year.

Response: We thank the commenter for the suggestion. The measure is designed to assess the patient's risk at the start of the MIPS measurement year and then evaluate how well clinicians manage their patients' risk. We therefore adjust for risk factors present before the start of and not during the measurement year. We also have tailored the outcome to exclude cancer-related admissions that reflect optimal cancer care. Specifically, the measure considers admissions for chemotherapy and non-emergent cancer surgeries as planned and does not include them in the measure outcome. CMS appreciates, however, the goals of alignment across measures, and will examine the opportunities to aligning further across measures when the measure is reevaluated.

One commenter expressed concern about the variables used to identify frailty. The commenter stated the variables could be prone to misclassification; patients could procure durable medical equipment without necessarily being considered medically frail. The commenter referred to two alternative methods documented in literature to determine frailty from Medicare administrative claims data: 1) Fried's Frailty Phenotype (Segal, Med Care, 2017) and 2) Rockwood's Frailty Index (Kim, J Gerontol A Bio Sci Med, 2018), and stated these methods may be more accurate than using DME data.

Response: CMS thanks the commenter for the suggestions. We are not aware of evidence suggesting that Medicare beneficiaries procure DME without need. Fried's frailty phenotype is largely based on clinical diagnoses that are already captured in the risk-adjustment model. We indeed did consider the Kim et al. (2018) paper in our definitions and coding of DME-based frailty variables. Kim evaluated numerous clinical variables that are already included in our risk-adjustment model and found that the DME-based variables were among the strongest predictors of admission risk. CMS will continue to monitor these variables during reevaluation.

One commenter asked for clarification on the codes included in the clinical risk-adjustment model. The commenter noted that the "other malignancies" variable is included in the supplemental Excel Workbook but not in the Methodology Report, and asked if it is included in clinical risk adjustment.

Response: We thank the commenter for their question, and appreciate the attention to detail they gave to the methodology report. The candidate risk variable in question, "other malignancies," is not included in the measure's final risk-adjustment model. It was a candidate for inclusion, and thus was included in the supplemental Excel workbook. It was not retained in the measure's final risk-adjustment model, however, because it did not meet the selection criteria for risk variables; its unadjusted rate ratio was less than the threshold of 1.3.

Measure Testing

One commenter requested specialty-specific analysis for the risk-standardized admission rates as provided for the unadjusted rates in the methodology report for public comment.

Response: We note that the measure is a TIN-level measure and thus calculate and report risk-standardized measure scores at the TIN level. In addition, as already noted, cancer specialists will not be included in the measure calculation and reporting as it is not designed to measure the quality of care provided by these types of clinicians.

One commenter requested clarification about whether CMS intends to apply the minimum sample size of 27 patients to individual clinicians or only to groups.

Response: CMS has not made a final decision about the minimal sample size for reporting, which will be informed by testing. However, the minimal sample size will apply to TINs, which includes both individual clinicians and clinical groups depending on how MIPS-eligible clinicians decide to report their quality, as this is a TIN-level measure.

Three commenters recommended alternate cutoffs for reliability. Of these, two commenters suggested 0.7, and one commenter suggested 0.7.

Response: CMS thanks the commenters for their suggestions about reliability cutoffs. CMS' goal is to include in the measure only providers with reliable measure scores. Although there is no clear consensus in the literature, most literature suggests that a cut-off of 0.5 is considered moderate or substantial reliability.[7,8] CMS used this value to determine the minimum cut-off to balance the need for reliable measure scores while maximizing the impact the measure could have on its beneficiaries. By including more providers, CMS is able to impact more beneficiaries. Although, CMS uses this value to set the minimum cut-off for inclusion in the measure, it is important to note that the median reliability was 0.7, which indicates that half of TINs have values greater than 0.7, while the other half of providers have values between 0.5 and 0.7.

Two commenters requested CMS complete validity testing in addition to face validity by the TEP. Both commenters noted face validity by the TEP is not sufficient. One of the commenters recommended CMS consider testing to demonstrate the measure is correlated to other MIPS measures such as the MIPS HWR or total per capita cost (TPCC) measures. The second commenter suggested CMS resolicit stakeholder feedback after more valuation of the measure's reliability and not proceed with the measure until it is reviewed by a third-party multi-stakeholder organization such as the NQF, MAP, its own Performance Measurement Committee as it has also recommended CMS to do for all cost and quality measures.

Response: CMS appreciates the need for broader stakeholder review and engagement. CMS intends to submit the measure to the MAP and for NQF endorsement. CMS has not yet validated the measure against other outcome measures since none target the same population and quality domain, so the expected correlation is unknown; however, CMS will explore validation options as it prepares the measure for NQF submission.

Use and Usability

Two commenters provided input on the measure's use. Of these:

- One commenter recommended CMS not move forward with the measure at the individual clinician (TIN/NPI) level unless the measure is deemed valid and reliable at the individual-clinician level. The commenter further suggested CMS allow for a voluntary (informational) reporting period for the measure during which the agency would provide regular feedback to

[7] Shrout PE, Fleiss JL. Intraclass correlations: uses in assessing rater reliability. *Psychological bulletin.* 1979;86(2):420.
[8] Landis JR, Koch GG. The measurement of observer agreement for categorical data. *Biometrics.* 1977;33(1):159-174.

clinicians but not tie payments to individual clinicians' performance. The commenter favored CMS evaluating the measure at the TIN level and if a clinician chooses to report as an individual clinician, applying the group (TIN) score to the TIN/NPI.

- One commenter stated it is unclear whether the MIPS MCC measure would be one that is automatically applied or one that clinicians would be able to select for reporting. The commenter anticipated CMS would propose specifics for the measure during the agency's notice of proposed rulemaking (NPRM).

Response: CMS thanks the commenter for their input. CMS has not yet finalized the MCC measure for use under MIPS. As with all other MIPS measures, CMS would include the measure in the NPRM process and vet how the measure would be implemented therein and for whom.

One commenter provided input on the measure's usability. The commenter recommended CMS provide frequent performance feedback for this and all MIPS measures to clinicians at a minimum on a quarterly basis and ideally work towards providing real-time data.

Response: CMS appreciates the input provided by the commenter. While MACRA does not require providing quarterly feedback reports, CMS agrees providing timely and frequent feedback is beneficial for clinicians to gain insights on their performance and opportunities for improvement. Should CMS implement this measure under MIPS, CMS will consider how and when to provide performance feedback to clinicians to increase understanding of the measure and promote quality improvement.

One commenter stated concerns with the measure and urged CMS to not move forward with the measure for accountability purposes in the short-term. The commenter expressed concern with the measure's attribution (discussed above) and about the categorization of the measure as a quality measure; the commenter noted the measure is calculated using administrative claims data like cost measures in use.

Response: CMS appreciates the commenter's concerns. CMS clarifies the MCC measure is designed to evaluate the quality of care provided by ambulatory clinicians to MCC patients, not episodes of care as cost measures do. The MCC measure addresses the healthcare priority of promoting effective prevention and treatment of chronic disease. It underwent a comprehensive 2-year development process with input from a national TEP. CMS will monitor and evaluate the concerns about attribution brought up by the commenter during measure reevaluation.

Preliminary Recommendations

Based on input during the public comment period, we will update the measure in the following way:

1. Not include hematologists as specialists evaluated by the measure as the measure is not designed to assess the quality of care delivered by these providers.

2. Exclude patients assigned to hematologists/oncologists by the attribution algorithm from the measure, as the outcomes for patients who are predominantly cared for by hematologists/oncologists, including patients actively being managed for cancer, do not likely reflect primary care physician or other relevant specialists' quality.

In addition, CMS will consider additional analyses and potential modifications to the measure specifications during reevaluation related to the following issues:

1. Explore approaches to prospective attribution as the Patient Relationship Categories and Codes become routinely used and recorded in Medicare administrative claims data.
2. Consider aligning the definition and handling of heart failure in the MIPS MCC and heart failure admission measures.
3. Consider adding cognitive and mobility late effects to broaden identifications of patients with stroke/TIA to the measure cohort.
4. Conduct additional social risk factor analyses to explore differential effects between rural and non-rural areas.
5. Examine options for further validating the measure.
6. Further examine and consider aligning risk factor observation periods with those used for other MIPS measures if valid for the MCC measure.

CMS will also consider how and when to provide performance feedback to clinicians to increase understanding of the measure and promote quality improvement, if and when implemented under MIPS.

Overall Analysis of the Comments and Recommendations

CMS/CORE appreciate the commenters' thoughtful input, recommendations, and request for clarifications about the measure. CORE has shared this input with the measure's TEP. CMS made immediate updates to the measure as described throughout the report and summarized in the Preliminary Recommendations section. CMS will further consider the input and potential updates to the measure during measure reevaluation.

Public Comment Verbatim Report

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
May 8, 2019	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	The PCPI appreciates the opportunity to comment on the draft measures included within the "Development of Outpatient Outcome Measures for the Merit-based Incentive Payment System (MIPS)" project led by Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation (CORE). While we support the development of additional outcome measures to assess the quality of care provided to Medicare beneficiaries by clinicians or clinician groups, we respectfully submit the following comments for consideration. The PCPI would like to comment on the identification of provider types to whom the measure should apply. In particular, PCPI would like to comment on CMS' assumption that primary care providers (PCPs) and specialists covered by the measure are "quarterbacking" the care of patients with MCCs. While PCPs often do quarterback the care of patients, they also commonly refer to subspecialists, particularly for more unstable problems. The more complex patients are, the more "noise" there will be in terms of attribution, (i.e., patients will see more providers that will impact the risk of admission). This would be applicable for a good deal of specialties, in particular, those who see patients with complex, degenerative conditions, who depend on multiple subspecialists to provide care. A large enough sample size may reveal a signal, perhaps for group reporting or for an Accountable Care Organization, (ACO), but the measure is not meaningful at the individual provider level. To that end, PCPI seeks issue with modifying a measure that was developed to assess care delivered jointly by groups of providers who share responsibility for patient care and outcomes, such as ACOs, and holding individual providers accountable. In addition, we are concerned that this measure was categorized as a quality measure, but is calculated through administrative claims and acts similar to other cost measures in use. The PCPI recommends CMS consider a multiple attribution model, similar to those recommended for the inpatient outcome measures, that attributes the outcome to both specialists and PCPs. Another alternate approach (which was previously recommended for the inpatient all-cause	Courtney Hurt, MSW, LCSW; Project Manager, Measure Development Operations; Physician Consortium for Performance Improvement (PCPI)	Courtney.Hurt@thepcpi.org	Professional society

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
		30-day readmission measure) is that of including both the discharging physician and the outpatient PCP for attribution. Given the many issues, PCPI recommends that CMS not move forward with this measure for accountability purposes in the short-term, but rather keep this measure in the development and test-only mode until the issues as described can be addressed. Thank you for your time and consideration.			
May 8, 2019	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	The American Academy of Neurology (AAN), an association of more than 34,000 neurologists and neuroscience professionals, is pleased to provide comment on "Development and Reevaluation of Outpatient Outcome Measures for the Merit-based Incentive Payment System." • It is not fair to assume that PCPs and specialists covered by the measure are quarterbacking the care of the patients with MCCs. Neurologists should not be linked to this measure of unplanned hospitalizations and ED visits for any of the below disease states other than stroke or TIA. We recommend that CMS develop specific outcome measures for specialists to ensure value of specialty care and decrease burn-out and lack of control felt by specialists. Lumping is not the answer. Coordination of care will occur in a multidisciplinary fashion for outcome measures developed for disease states seen and germane to the neurologists. Improvements in disease states can occur with improved outcomes by targeting specifics versus lumping. • Good measures should be adjusted for dual-eligibility status. However, this proposal in its current form is not adequate for neurologists. • Several of the studies included in the report did not demonstrate a decrease in hospitalizations. • The report also does not provide a strong evidence base to support that a physician can drive improvements in the absence of some program involving other partners or payment offset (e.g., care management fee). • A clinician or group's ability to drive improvements on this measure is limited due to the attribution model used, which is retrospective.	Erin Lee; Program Manager, Measure Development; American Academy of Neurology	elee@aan.com	Professional society

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
		• This attribution along with the use of administrative data that is not timely make it difficult for physicians to drive toward reductions in admissions. • Since the overall score adjustment is subject to change through rulemaking and the measure results will be reported and points earned based on the individual measure score, it seems prudent to also adjust for dual eligible status at this time. Thank you for the opportunity to provide comments.			
May 8, 2019	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Overall, the methodology and composition of the TEP is considered well written and representative. The panel includes advanced practice nurses; these are key stakeholders in merit-based incentives for acute, unplanned admissions. Despite high quality care, some proportion of unplanned admissions due to complications of procedures or surgeries, accidents, or a high rate of recurrence for specific conditions may not be avoidable and therefore consideration for this (page 10) is supported. There is agreement for the discussion on Page 11 which acknowledged that the availability of behavioral health resources is challenging yet noted that depression is a comorbidity and a major reason for hospital admission. The amount of patients that present with mental health complaints to the emergency department is increasing significantly. With the limited resources available, outpatient providers should not be penalized. Regarding a buffer period for hospital readmissions (p 14), council members agree that the readmission of hospice patients should be excluded. This may in no way reflect the quality of patient management and often has cultural and emotional influences that are not in the control of the care team. The concept of a buffer period following discharge is supported. Further study is needed and any defined interval for the determination of merit-based incentives should be grounded in evidence according to condition and risk stratification. A council member shared that they recently completed a small study (n=80) of patients who returned to be seen within 30 days of discharge and the average return time was 13.5 days. Majority of these patients still had not had the opportunity to see their PCP prior to returning for care.	Lisa Caldeno; Executive Office Specialist; Emergency Nurses Association	lisa.calendo@ena.org	Professional society

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
		Incorporating primary care providers and specialists into the determination of incentive-based payments is therefore supported. It is suggested that incentives be strongly supported for demonstration of transitions in care. Thank you for the opportunity to review this important document.			
May 15, 2019	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	The American Geriatrics Society (AGS) appreciates the opportunity to comment on the measure of acute admissions for patients with multiple chronic conditions (MCCs) developed by the Centers for Medicare & Medicaid Services (CMS) and Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation (CORE) for quality reporting under the Merit-based Incentive Program (MIPs). Founded in 1942, the AGS is a nationwide, not-for-profit society of geriatrics healthcare professionals dedicated to improving the health, independence, and quality of life of older people. Our nearly 6,000 members include geriatricians, geriatric nurses, social workers, family practitioners, physician assistants, pharmacists, and internists who are pioneers in advanced-illness care for older individuals, with a focus on championing interprofessional teams, eliciting personal care goals, and treating older people as whole persons. The Society provides leadership to healthcare professionals, policymakers, and the public by implementing and advocating for programs in clinical care, research, professional and public education, and public policy that can support us all as we age. Below please find our response to CMS and CORE's specific questions as well as other general feedback. **2.3 Cohort Definition** The AGS recommends adding late effects to the list of chronic disease groups in addition to acute stroke events. Cognitive and mobility late effects are what make an older patient complex. For example, someone with a stroke two years ago with residual gait impairment would be in the cohort. **2.5.1 Clinicians Covered by the Measure** *Question 1: Has CMS appropriately identified the provider types to whom the measure should apply? That is, is it fair to assume the PCPs and specialists covered by the measure are quarterbacking the care of the patients with MCCs? Are there other specialties to whom the measure should apply?*	Anna Mikhailovich; Manager of Public Affairs and Advocacy; American Geriatrics Society	amikhailovich@americangeriatrics.org	Professional society

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
		The AGS believes that psychiatrists should be included in the list of "relevant" specialists for patients with depression or dementia as they could potentially play a "dominant" role for such patients. Furthermore, the AGS believes that additional medical subspecialists should be covered by the measure, such as infectious disease specialists (HIV), rheumatologists (rheumatoid arthritis, lupus) and even gastroenterologist (inflammatory bowel disease, end-stage liver disease). We would also like to note that some geriatricians act as primary care providers (PCPs) while others serve as specialists. For example, one of our members – a geriatrician outpatient practitioner – mentioned that he has been asked to perform single visit consultations for cardiologists and oncologists who "quarterback" care for their MCC patients. It seems like the approach to assign a "dominant" specialist could lead to an accurate attribution of patients to responsible clinicians. **2.5.3 Approach to Attribution at the Individual Clinician Level** Overall, the AGS believes that the methodology is reasonable. However, we would like to ask CMS/CORE to clarify whether the diagnosis for the acute admission could be used in attribution. For example if a patient was seen twice by a PCP and twice by a cardiologist, the patient would be attributed to the PCP. If this patient has a chronic obstructive pulmonary disease (COPD) admission, it would be reasonable to attribute that admission to the PCP. However, if the patient has a heart failure admission, the cardiologist should be equally responsible. We also would like to ask – who would be the "dominant" specialist" if a patient with multimorbidity, for example, sees a cardiologist six times per year and a nephrologist five times per year? **3.3.3 Interpretation, Discussion, and Request for Comment on Adjustment for Social Risk Factors** *Question 2: Should CMS adjust the measure for Medicare-Medicaid dual-eligibility status? CMS is proposing to adjust the measure for two community context variables – 1) Agency for Healthcare Research and Quality (AHRQ) Socioeconomic Status (SES) Index and 2) specialist density – consistent with the conceptual model of how these factors may affect the outcome. CMS evaluated but did not include dual-eligibility status in the preliminary model, given that the program already adjusts MIPS scores for providers based on their proportion of dual-eligible patients and that adjusting has downsides. However, CMS is seeking comment on the*			

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		approach to dual-eligibility status as research and policy is evolving in this area. Yes, the AGS recommends that CMS and CORE adjust the measure for Medicare-Medicaid dual-eligibility status. Dual-status has been shown to be a strong risk factor for readmissions. The other measures are related to dual-status but are not identical. For example, the AHRQ SES Index is a neighborhood-level index, which would not capture poor people living amongst less-poor neighbors. Adjusting scores for providers with a higher proportion of duals most directly deals with provider-level issues in caring for many duals, e.g. whether more outreach is needed, more support staff to connect with home care, etc. **3.3.4 Preliminary Risk-adjustment Model** The AGS is concerned that the measures of frailty/disability in the preliminary risk-adjustment model are prone to miss-classification. For example, what if a patient received a walker or cane for a reversible illness? What if they purchased a walker or cane on their own? What if they received a walker or cane years ago prior to the look back period described in the "Methods" section? There are claims based methods for determining frailty from Medicare data based on Fried's Frailty Phenotype (Segal, Med Care, 2017) and also Rockwood's Frailty Index (Kim, J Gerontol A Bio Sci Med, 2018). One of these resources may be more accurate than durable medical equipment (DME) use. We are also concerned that certain diagnoses included in the risk-adjustment model are either not preventable or only minimally preventable even with high-quality primary care. For example, hospital admissions for surgical emergencies such as diverticulitis, acute cholecystitis or bowel obstruction are not preventable. It could also be argued that admissions for certain types of acute infection are not preventable or only minimally preventable even with the best outpatient care, e.g. urinary tract infections. **General Feedback** Lastly, we would like to note that there are many factors that affect hospital admissions that are beyond the PCP's control and therefore admissions are often not reflective of the PCP's quality of care. We realize that measuring quality of care is difficult, and admissions may be the best that we have. If that is the case, we encourage CMS to make adjustments (as possible) for a given hospital's admission rates per MCC (i.e. what is			

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		the hospital's admission rate for COPD exacerbations, HF exacerbations, etc.?)			
May 22, 2019	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	The American Society for Radiation Oncology (ASTRO) is pleased to provide brief comments on the proposed quality measure of acute hospital admissions for patients with multiple chronic conditions (MCCs) currently being developed by Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (CORE). This measure is being developed for use in the Centers for Medicare & Medicaid Services' (CMS) Merit-Based Incentive Payment System (MIPS) program. We appreciate that you extended the comment period for this measure given its importance. ASTRO is the premier radiation oncology society in the world, with nearly 11,000 members in the United States and around the globe who are physicians, nurses, biologists, physicists, radiation therapists, dosimetrists and other health care professionals that specialize in treating patients with radiation therapies. As the leading organization in radiation oncology, the Society is dedicated to improving patient care through professional education and training, support for clinical practice and health policy standards, advancement of science and research, and advocacy. The measure population includes Fee-for-Service Medicare beneficiaries who have two or more of the following nine chronic conditions: 1. acute myocardial infarction; 2. Alzheimer's disease and related disorders or senile dementia; 3. atrial fibrillation; 4. chronic kidney disease; 5. chronic obstructive pulmonary disease or asthma; 6. depression; 7. diabetes; 8. heart failure; and 9. 9. stroke or transient ischemic attack. The methodology document states that this measure covers primary care providers (PCPs) and a subset of specialists who may typically be expected to coordinate or "quarterback" care for MCC patients and in that role would be expected to be able to minimize their risk of unplanned admissions through the provision of high-quality care. The	Emily Wilson; Executive Vice President; American Society for Radiation Oncology	emily.wilson@astro.org	Professional society

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
		measure is designed to work for MIPS eligible clinicians who report under MIPS as individuals or as groups (as defined by the program) under a common Taxpayer Identification Number (TIN). Based on input from the TEP, specialists covered by the measure are limited to those who "plausibly provide overall coordination of care for patients with MCCs and who manage the chronic diseases that put the MCC patients in the measure at risk of admission." These specialists (defined using the Medicare Provider Specialty Codes) include cardiologists, pulmonologists, neurologists, endocrinologists, and radiation oncologists. Patients are attributed to MIPS eligible clinicians using a visit-based algorithm that assigns patients to the PCP with the most visits, unless there is a "dominant specialist" likely coordinating care. In its request for public comment, Yale/CMS specifically asks: Has CMS appropriately identified the provider types to whom the measure should apply? That is, is it fair to assume the primary care providers (PCPs) and specialists covered by the measure are quarterbacking the care of the patients with MCCs? Are there other specialties to whom the measure should apply? We appreciate the complexity of this issue and the explanation of the various options that were considered. According to the attribution algorithm option C, which is the most focused on visits over charges, the dominant specialist is defined as one having two or more visits with the patient compared to the PCP and any other specialist. Most patients who receive radiation therapy have treatment daily for several weeks and see the radiation oncologist numerous times for initial consult, during treatment, and then for follow up. This attribution model could capture many patients and assign them to radiation oncologists. However, earlier this year, ASTRO conducted a member survey to gather information about practice patterns of radiation oncologists in the United States. We had over 950 respondents to our survey. We included a comprehensive list of possible activities and asked our members to indicate if they routinely, occasionally, rarely or never provided the service. As expected, management of radiation-related symptoms was the most routinely offered service with 98% of ASTRO members responding positively. The next three most routinely offered services are management of cancer-related symptoms (78%), narcotic/analgesic			

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		prescriptions (66%), and palliative care (55%). Only 2% of ASTRO members said that they routinely provide primary care services and 54% reported that they never provided primary care services. Further, only 3% of ASTRO members routinely admit patients to inpatient service while 82% reported that the never admit patients to the hospital. While conceptually we think the algorithm has merits, we are concerned that in practice it may have fatal flaws. The methodology document states that, based on input from the TEP specialists covered by the measure are "limited to those who plausibly provide overall coordination of care for patients with MCCs and who manage the chronic diseases that put the MCC patients in the measure at risk of admission." However, our recent member survey suggests that there is no reason to believe that a radiation oncologist would manage any of the chronic conditions identified in the measure. Perhaps one refinement to the attribution methodology could be that the physician to whom the patient is attributed must have included at least one of the relevant ICD codes for the MCCs to trigger the attribution analysis. We thank Yale CORE and CMS for this opportunity to provide comments on the proposed MCC measure and hope this practical information will help with the refinement of the attribution model.			
May 23, 2019	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	The American Society of Clinical Oncology (ASCO) appreciates the opportunity to provide comments on a proposed quality measure of acute hospital admissions for patients with multiple chronic conditions (MCCs) currently being developed by Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (CORE). This measure is being developed for use in the Centers for Medicare & Medicaid Services' (CMS) Merit-Based Incentive Payment System (MIPS) program. ASCO is the national organization representing more than 45,000 physicians and other health care professionals specializing in cancer treatment, diagnosis, and prevention. ASCO members are also dedicated to conducting research that leads to improved patient outcomes, and we are committed to ensuring that evidence-based practices for the prevention, diagnosis, and treatment of cancer are available to all Americans, including Medicare beneficiaries. **MCC Measure Development Overview**	Angela Kennedy; Director, Measure Development; American Society of Clinical Oncology	angela.kennedy@asco.org	Professional society

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
		This proposed MIPS MCC admission measure aims to provide an assessment of the quality of care provided by ambulatory clinicians who manage the care of patients with MCCs. The measure uses the outcome of acute, unplanned admissions to assess care quality, and is intended for use under MIPS to assess the performance of MIPS eligible clinicians. In order to develop this measure, CMS asked CORE to adapt its existing outcome measure developed for and currently used in CMS's Accountable Care Organization (ACO) quality measure set. The ACO measure of risk-standardized acute, unplanned admission rates was designed to assess ambulatory care delivered jointly by ACOs, groups of providers who share responsibility for patients' care and outcomes. CORE re-specified CMS's ACO measure for use in assessing individual or groups of clinicians participating in the Merit-based Incentive Payment System, with input from a national Technical Expert Panel (TEP). The re-specified measure for MIPS will assess each eligible clinician or clinician group's admission rate relative to that of other MIPS participating clinicians or clinician groups with similar patients. The measure, in brief, is a risk-adjusted outcome measure that uses the outcome of acute, unplanned admissions per 100 person-years at risk of admission to assess care quality. The measure outcome is the number of acute, unplanned hospital admissions per 100 person-years at risk for hospitalization during the measurement period. The numerator is the number of eligible admissions that occurred. The denominator is the patients' time at risk for hospitalization. Admissions are only counted while the patient is considered at risk. ASCO has reviewed the specifications and results of the MIPS MCC measure in the measure's methodology report, which presents the approach to measure development, the measure specifications, and results of measure evaluation and testing,1 and there are three main areas these comments address: attributed provider types, measure risk adjustment, and more broadly the use and application of the measure in MIPS. **Attributed Provider Types: Hematology/Oncology** The measure population cohort includes Medicare Fee-for-Service beneficiaries aged ≥65 years who have two or more of the following nine chronic conditions: 1) acute myocardial infarction, 2) Alzheimer's disease			

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		and related disorders or senile dementia, 3) atrial fibrillation, 4) chronic kidney disease, 5) chronic obstructive pulmonary disease or asthma, 6) depression, 7) diabetes, 8) heart failure, and 9) stroke or transient ischemic attack. The methodology document states that this measure covers primary care providers (PCPs) and a subset of specialists who may typically be expected to coordinate or "quarterback" care for MCC patients and in that role would be expected to be able to minimize their risk of unplanned admissions through the provision of high-quality care. The measure is designed to work for MIPS eligible clinicians who report under MIPS as individuals or as groups (as defined by the program) under a common Taxpayer Identification Number (TIN). The methodology document states that, "because we use the outcome of acute, unplanned admissions to assess quality, we limit the clinicians covered by the measure – those to whom CMS will attribute patients for measure score calculation -- to two categories of providers for whom this outcome reflects care quality. This includes 1) primary care providers (PCPs) and 2) a subset of specialists who manage the care of MCC patients." (PCPs for the purpose of this measure also include nurse practitioners, certified clinical nurse specialists, and physician assistants.) Based on input from the TEP, specialists covered by the measure are limited to those who "plausibly provide overall coordination of care for patients with MCCs and who manage the chronic diseases that put the MCC patients in the measure at risk of admission." These "relevant" specialists (defined using the Medicare Provider Specialty Codes) include cardiologists, pulmonologists, nephrologists, neurologists, endocrinologists, and hematologists/oncologists. Patients are attributed to MIPS eligible clinicians using a visit-based algorithm that assigns patients to the PCP with the most visits, unless there is a "dominant specialist" likely coordinating care. A dominant specialist is defined as one having two or more visits with the patient compared to the PCP and any other specialist. In its request for public comment, Yale/CMS specifically asks: Has CMS appropriately identified the provider types to whom the measure should apply? That is, is it fair to assume the primary care providers (PCPs) and specialists covered by the measure are quarterbacking the care of the patients with MCCs? Are there other specialties to whom the measure should apply?			

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		In response, we offer the following considerations. This revised attribution algorithm provides estimates of patient attribution to hematology/oncology in addition to the other specialties proposed for inclusion in the measure. The algorithm per se is logical, but it is only relevant if there is a rational basis for attributing the clinical conditions to a dominant specialist (in this case specifically, hematology / oncology). As noted earlier, the methodology document states that, based on input from the TEP, specialists covered by the measure are "limited to those who plausibly provide overall coordination of care for patients with MCCs and who manage the chronic diseases that put the MCC patients in the measure at risk of admission." There is little reason to believe that a hematologist/oncologist would manage a patient with two or more of these chronic conditions, unless such a patient also has cancer or a major blood disorder. First, it is unlikely that—absent a cancer diagnosis—oncologists would manage the non-oncologic chronic diseases on this list; second, unlike the other specialties listed for attribution, there is no clear link between hematology/oncology and the MCCs listed. In other words, it is plausible that a cardiologist might manage atrial fibrillation or heart failure; a pulmonologist might manage COPD or asthma; a nephrologist might manage CKD; a neurologist might manage stroke/TIA or Alzheimer's disease; and an endocrinologist might manage diabetes. However, none of the nine chronic conditions on this list would normally be managed primarily by an oncologist. Given that cancer is not the focus of this model, inclusion of the hematologist/oncologist seems arbitrary and we believe should be removed from the list of relevant specialties. **Risk Adjustment** Below we briefly address three concerns related to measure risk adjustment: specific condition categories (CCs) proposed for use in risk adjustment, the use of comorbidities from prior years, and a lack of information on risk-standardized admission rates. The methodology document includes "advanced cancer" (CC 8, 9, 10, 13) as clinical comorbidities in risk adjustment, along with "hematological diseases" (CC 46, 48). These six condition categories are also listed in the methodology report supplement (i.e. the Excel file accompanying the methodology document). However, "other malignancy" (CC 11, 12) is listed in the Excel file but not in the methodology document itself. Was			

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		"other malignancy" omitted from the methodology document intentionally, or was it an oversight? We have earlier expressed our concerns in relation to other claims-based measures regarding the application of comorbidities in risk adjustment wherein the patient's conditions from the prior calendar year (e.g. 2018) are used to predict the risk of an adverse event in the performance year (e.g. 2019). This proposed measure would do the same. In the case of chronic conditions where an adverse event is expected to remain stable or increase over time, the use of such a prospective methodology may work. However, in the setting of a cancer diagnosis, there is usually an acute phase, followed by a chronic phase. The use of the prior year's comorbidities appropriately adjusts for patients living with cancer in a chronic phase – for example, survivors and patients on long-term maintenance. However, this methodology does not account for newly diagnosed patients presenting to an oncologist in the current year. These patients, in their acute phase, have a higher likelihood of adverse events such as admissions, as well as a higher likelihood of being primarily managed by the oncologist. In the proposed measure (as with the total cost-per-capita measure), their new disease is not accounted for in the risk adjustment, as it was not present in the prior calendar year. Potential options to fix this issue include consideration of all diagnoses from the prior and current calendar year, up to the second visit of the attributed provider (this framework is used in the Medicare Spending per Beneficiary and other episode-based programs), or the exclusion of patients presenting with a new, select diagnosis in the current calendar year. ASCO would be happy to discuss option to improve these measure specifications further. Finally, while the unadjusted admission rate by specialty was given in the methodology document, we did not find a specialty-specific analysis for the risk-standardized admission rates. We believe it would be important to also share this information in the context of consideration of the proposed measure. **Use and Application of the Measure in MIPS** While the methodology document refers to the proposed measure as a "quality" measure for use in MIPS, the measure would be calculated via administrative claims and not reported by clinicians, unlike the vast majority of other MIPS quality measures.2 We recognize it is beyond the			

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		scope of the methodology document to discuss the application of this measure to MIPS—we anticipate that CMS would propose specifics for the measure's use during the agency's normal cycle of notice-and-comment rulemaking—but we did want to raise some questions for considerations at this stage. A core tenet of the quality category of MIPS is the ability of clinicians to choose quality measures that best reflect their patients and scope of practice, i.e. measures that are meaningful to them. It is not at all clear from the material released to the public so far if this measure will in fact be optional or required by CMS for scoring. If the latter, several questions arise: Will a MIPS clinician's ability to select their quality measure be protected? If there are no other outcome measures that apply to a clinician, will this outcome measure automatically apply to them? We thank Yale CORE and CMS for this opportunity to provide comments on the proposed MCC measure and would be happy to discuss our views and potential changes to the measure further with you. Please contact Karen Hagerty at Karen.Hagerty@asco.org with any questions.			
May 24, 2019	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Measures Methodology Report: Clinician and Clinician Group Risk-standardized Hospital Admissions Rates for Patients with Multiple Chronic Conditions, prepared for CMS by Yale New Haven Health Center for Outcomes Evaluation and Research (CORE). The AAMC is a not-for-profit association dedicated to transforming health care through innovated medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 154 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in biomedical sciences. The AAMC appreciates the opportunity to comment on this report, which presents a newly adapted measure for use in the Merit-based Incentive Payment System (MIPS), currently described as a measure of acute,	Kate Ogden, MPH; Policy and Regulatory Analyst, Physician Payment and Quality; Association of American Medical Colleges	kogden@aamc.org	Professional society

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		unplanned hospital admissions for patients with multiple chronic conditions (MCCs) that CMS currently reports for Medicare Accountable Care Organizations (ACOs). The new measure is a risk-adjusted measure that uses the outcome of acute, unplanned 100 person-years at risk of hospital admission to assess care quality. Additionally, the existing measure was adjusted to capture attribution, as Medicare beneficiaries typically see multiple health care providers in the outpatient setting. Patients are attributed to eligible clinicians using a visit-based algorithm that assigns patients to the primary care provider (PCP) with the most visits, unless there is a dominant specialist coordinating care. The AAMC is appreciative that the report clearly outlines the rationale for this new measure and of the thoughtful process to determine attribution methodology. However, there were several items that were not clearly outlined in the report, which we will provide additional comment on below. **Evidence Supporting the Measure** While CMS provides evidence in this report to demonstrate that improved care coordination can lead to reductions in hospital admissions, the majority of the evidence cited involved multiple partners on the care coordination team, such as health systems and/or hospitals. The report also does not provide a strong evidence base to support the premise that a physician can drive improvement in the absence of a program involving other partners or payment incentive to account for the time spent on activities like care coordination. The AAMC feels that including these partners in care coordination or in programs and efforts focused on care management would be beneficial and suggests that CMS consider incorporating a payment incentive for these efforts. **Attribution Approach** The AAMC appreciates that this report adequately describes the various attribution options that were explored for both individual and group assignment of patients, and the National Quality Forum's (NQF) principles for selection of an attribution model. However, a clinician or clinician group's ability to drive improvements on this measure is limited due to the chosen retrospective attribution model. Retrospective attribution can make it difficult for clinicians to influence reductions in admissions. The AAMC is supportive of efforts to determine which physician is the "quarterback" for patient care, instead of having multiple providers			

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		assigned to one beneficiary. The AAMC feels that this attribution model will allow the measure to be as accurate as possible and capture the data from the most relevant patient interaction. We appreciate that the report took into account the fact that the patient may also be regularly seeing a specialist provider who may be a more effective "quarterback" for the beneficiary than their primary care physician, especially for a beneficiary with multiple chronic conditions (MCCs). The AAMC is supportive of this flexibility as it will allow for more meaningful measurement. **Risk Adjustment** There is significant peer-reviewed literature1 demonstrating that a performance on outcomes can be affected by factors outside the control of the physician (e.g. housing, food insecurity, social support, transportation). The AAMC appreciates that CMS has agreed to include AHRQ Socioeconomic Status (SES) index and specialist density as part of the adjustment for social risk factors. However, Yale CORE tested the social risk factors after assessment of clinical and demographic risk factors. It remains unclear why this multi-step approach was used, as it appears to be contrary to the guidance that the NQF Disparities Standing Committee has provided. CMS requested specific input on whether the measure should also be adjusted for dual eligibility. There is precedent for this adjustment in the hospital readmissions program where CMS has implemented some risk adjustment by stratifying penalties by the proportion of Medicare and Medicaid dual eligible patients the hospital serves. As a first step, we believe it is appropriate to adjust this measure for dual eligible status. We believe adjustments for SES should be considered at the overall MIPS group and individual level and at the measure level to make accurate quality comparisons. CMS also needs to explore additional social risk factors beyond dual eligible status that impact performance on quality **Reliability and Validity Testing** Yale's report clearly outlines the options for the individual clinician attribution approach, along with the rationale on why one approach was selected over the other. Unfortunately, the report does not provide the same information on which of the two options were selected for group attribution. As a result of this, it is unclear what attribution approach was used in the testing at the group level. The AAMC asks that CMS provide			

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		additional information on the approach and rationale for which attribution approach was used in the testing at the group level. The AAMC appreciates the opportunity to comment on this report, and we look forward to continued engagement on these important issues. If you have any questions, please contact Gayle Lee at (202) 741-6429 or galee@aamc.org.			
May 24, 2019	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	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	Suzanne Joy, MPP; Senior Associate, Regulatory Affairs; American College of Physicians	sjoy@acponline.org	Professional society

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		lead to adverse consequences on practices and more importantly, patients. If patient attribution and risk adjustment methodologists 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,			

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		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 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			

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		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 patent'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			

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		of the adverse consequences that can come with claims-based attribution identified below. **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			

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		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			

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		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			

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		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;			

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		• 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.			
May 24, 2019	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	The American Medical Association (AMA) appreciates the opportunity to comment on the Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure for use in the Merit-based Incentive Payment System (MIPS). The AMA strongly believes that it is useful to understand the rate of admissions for patients with multiple chronic conditions particularly for quality improvement. However, measures used in accountability programs must be (1) based on strong evidence, (2) actionable to ensure that improvements can be driven by those held accountable, and (3) proven to be reliable and valid at all levels to which the measure is attributed. Based on the information released for public comment, we believe that additional work is required to meet these minimum criteria and this measure is not ready for implementation in MIPS at this time. <u>Evidence to support the measure at the clinician and group levels</u> The AMA believes that attribution must be determined based on evidence that the accountable unit is actually able to meaningfully influence the outcome, which aligns with the most recent National Quality Forum (NQF) report, Improving Attribution Models.1 This principle is also aligned with the evidence requirements for outcome measures in the NQF Measure Evaluation Criteria, which requires that there be at least one structure or process where the clinician can influence the outcome and this relationship must be demonstrated through empirical evidence.2 CMS must begin to demonstrate these relationships for an accountable unit prior to implementing this measure in MIPS and we do not believe that CMS has adequately demonstrated this link.	Koryn Rubin; Assistant Director, Federal Affairs; American Medical Association	Koryn.Rubin@ama-assn.org	Professional society

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		While the AMA agrees that evidence exists to demonstrate that improved care coordination and programs focused on care management can lead to reductions in hospital admissions, the majority of the cited evidence involved multiple partners such as a health system and/or hospital. We also note that not all of the studies demonstrated a decrease in hospitalizations. We do not believe that sufficient evidence was provided to support that physicians or practices in the absence of some coordinated program or payment offset (e.g., care management fee) can implement structures or processes that can lead to improved outcomes for these patients. Since the care coordination programs and initiatives are mostly led by health plans, integrated delivery systems, accountable care organizations, or other broader entities, assignment of responsibility for the reduction of admissions to individual physicians and practices in MIPS is inappropriate. As CMS continues to expand the types of measures for possible use in MIPS, CMS must establish the underlying evidence used as the basis to attribute a clinical outcome to a specific measured entity such as physician. Therefore, we do not believe that CMS provided sufficient information to support the attribution of this measure to physicians or practices. <u>Actionability of the measure</u> The AMA appreciates the thorough evaluation of the various attribution approaches considered and additional clarification on TIN level attribution. While we believe that the options selected are the most reasonable, we are concerned that a clinician's or group's ability to drive improvements on this measure is limited because the developer is using retrospective attribution. The AMA understand that it remains difficult to implement measures that use prospective attribution. However, CMS must begin to explore approaches that more clearly assign patients to physicians and practices in advance of the reporting year to better enable them to drive improvements. The current approach toward attribution along with the use of administrative data that is not timely makes it difficult for physicians to drive toward reductions in admissions. In addition, the lack of alignment of the various attribution models used for the MIPS outcome and cost measures such as this measure, the Hospital-wide Readmissions (HWR) measure and Total Per Capita Cost (TPCC) measure must be addressed. Based on the proposed changes to			

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		attribution in many of these measures to hold more than one physician accountable and/or leverage different approaches (e.g., plurality of charges vs. plurality of visits), physicians and practices will have different patients assigned to them for different measures. This lack of consistency across measures will further decrease a physician's ability to drive improvements in care as they will not be working with a pre-determined set of patients. Rather, patients will be assigned retrospectively and could be assigned to more than one clinician. This scattershot approach within one program is not sustainable and must be addressed to create a system that promotes and facilitates improvements to patients in a way that is also meaningful and actionable by physicians. Therefore, the AMA is extremely concerned that the multiple attribution approaches across measures defeats this purpose and it must be addressed immediately by CMS. Otherwise, this approach will only further increase physician frustration about MIPS and unnecessarilyy increase administration burden. Rigor of scientific acceptability testing and results The AMA supports and is encouraged to see that social risk factors were tested and will be included in the risk adjustment approach. **We strongly recommend that dual eligibility be included in the adjustment since the adjustment of a factor should not be dependent on whether it is also adjusted in the overall score within a program as each serves a different purpose**. Bonus points, such as what occurs in MIPS are not always permanent and often minimal to offset the handicap a physician may have compared to their peers who do not treat a large portion of patients with social risk factors. It is also unknown if the additional points added to a physician or practices overall score are enough for compensating physicians who treat patients with social and economic issues. Furthermore, given that the testing demonstrated that dual eligibility was strongly predictive of an admission, we believe that this variable should be included in the final model. We also remain concerned that CMS continues to test social risk factors after assessment of clinical and demographic risk factors and it is unclear why this multi-step approach is preferable. On review of the Evaluation of the NQF Trial period for Risk Adjustment for Social Risk Factors report,3 it is clear that the approaches to testing these data should be revised to strategies such as multi-level models or testing of social factors prior to			

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		clinical factors and that as access to new data becomes available, it may elucidate more differences that are unrelated to factors within a hospital's or physician's control. Additional testing that evaluates clinical and social risk factors at the same time or prior to clinical variables rather than the current approach with clinical factors prioritized should be completed. This additional testing may provide support for inclusion of additional variables such as primary care physician density and further emphasize the need to include dual eligibility. The AMA also encourages CMS to continue to ensure that measures meet minimum acceptable thresholds for testing such as 0.7 for reliability and demonstrate the validity when attributed to the physician or practice. Both reliability and validity must be demonstrated prior to implementation in MIPS. Specifically, we were only able to identify measure score reliability testing at the TIN level and could not find any information on what the reliability results were for individual clinicians. As a result, it is unclear whether it is CMS' intent to apply the minimum sample size of 27 patients or greater to individual clinicians or whether the measure will only be applied at the TIN level based on the testing provided. If at the TIN level, the level of the group size should be set at a number that meets high reliability (0.7). We request that CMS clarify whether the results provided are inclusive of individuals in addition to groups, including size of the group. If not, CMS needs to provide the results for the NPI/TIN level and clarify what minimum sample size for individual physicians is supported by the reliability testing. In addition, we recommend that CMS set the reliability target at 0.7 or greater. We acknowledge that this change would require that the minimum sample size be set at equal or greater 62 patients and reduces the number of TINs to which the measure would apply from 45.3 percent to 23.9 percent. However, even with this change, 81.9 percent of patients with multiple chronic conditions would still be included in the measure and further ensure that the results yield more reliable and accurate representations of the quality of care provided. As noted in the report, CMS must complete further testing to demonstrate the validity of the measures as they relate to each of the accountable units to which each measure is attributed. We recommend that CMS consider testing that demonstrates whether this measure			

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		attributed to physicians and practices is correlated to other outcome measures, such as hospital-wide readmissions (HWR) or total per capita cost (TPCC). Face validity alone should not be considered sufficient. Information of the results of the face validity testing would have been helpful to review in this report but, if it has not yet been completed, we encourage CMS to consider broadening those surveyed beyond the Technical Expert Panel as they may have an inherent bias given their participation in developing the measure. In conclusion, CMS must balance the desire to apply this measure to the broadest number of physicians possible with the unintended consequences of inappropriately attributing measures to physicians for which they cannot meaningfully influence patient outcomes. The AMA requests that CMS carefully consider the potential misinformation that could be provided to patients and caregivers if the measures do not have a clear evidence base to support attribution of the outcome to a specific physician and could potentially produce scores that are invalid and unreliable. The AMA appreciates the opportunity to provide our comments on the draft admission measure for use within MIPS. If you have any questions regarding our comments, please contact Koryn Rubin, Assistant Director, Federal Affairs, at koryn.rubin@ama-assn.org or 202-789-7408.			
May 24, 2019	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	The American Society of Hematology (ASH) is pleased to offer comments on the Measure Methodology Report for Public Comment: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC). ASH represents over 17,000 clinicians and scientists worldwide, who are committed to the study and treatment of blood and blood-related diseases. These disorders encompass malignant hematologic disorders such as leukemia, lymphoma, and multiple myeloma, as well as non-malignant conditions such as sickle cell anemia, thalassemia, bone marrow failure, venous thromboembolism, and hemophilia. In addition, hematologists are pioneers in demonstrating the potential of treating various hematologic diseases and continue to be innovators in the field of stem cell biology, regenerative medicine, transfusion medicine, and gene therapy. ASH membership is comprised of basic, translational, and clinical scientists, as well as physicians providing care to patients in diverse	Leslie Brady; Policy and Practice Manager; American Society of Hematology	lbrady@hematology.org	Professional society

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		settings including teaching and community hospitals, as well as private practice. ASH's main concern with this measure is the discrepancy between the chronic disease groups indicated for inclusion and the clinicians covered by the measure. CMS has specifically requested comment on whether the agency appropriately identified the provider types to whom the measure should apply. ASH does not think that the measure should apply to hematologists/oncologists. The patients included in the measure would have two or more of nine chronic disease groups in the year prior to the measurement period, including acute myocardial infarction (AMI), Alzheimer's disease and related disorders or senile dementia, atrial fibrillation, chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD) or asthma, depression, diabetes, heart failure, and stroke or transient ischemic attack (TIA). CMS plans to limit the clinicians covered by the measure to those to whom CMS will attribute patients for measure score calculation. This includes primary care providers as well as a subset of specialists, including hematologists/oncologists, who manage the care of MCC patients. The Society is concerned, however, that none of the chronic conditions listed are primarily managed by hematologists/oncologists, putting our members at a disadvantage for this measure. The attribution approach uses the plurality of evaluation and management visits and while ASH agrees that it is reasonable to focus on visits rather than charges, the Society feels it is inappropriate to assign non-hematologic conditions to the responsibility of a hematologist/oncologist. Thank you for the opportunity to provide comments on this particular measure. We welcome the opportunity to discuss these comments with you and your team. If you have any questions or require further clarification, please contact Leslie Brady, ASH Policy and Practice Manager, at lbrady@hematology.org or 202-292-0264.			
May 24, 2019	Clinician and Clinician Group Risk-standardized Hospital Admission	The Endocrine Society appreciates the opportunity to review the measure methodology report and provide feedback on the measure of hospital admissions rates for patients with multiple chronic conditions (MCC). As one of the relevant specialists covered by the measure, the Society's Quality Improvement Subcommittee reviewed the measure and offers the following feedback.	Stephanie Kutler; Director, Advocacy and Policy; Endocrine Society	skutler@endocrine.org	Professional society

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	Rates for Patients with Multiple Chronic Conditions	**Covered Physicians** While CMS has identified most of the physicians and specialties who will participate in the care of the relevant diseases, we are concerned that admissions will be attributed to the wrong physician in some cases. The physician quarterbacking for the patient is not always responsible for the disease process that causes admission. Quarterbacking as stated above means that the physician seeing the patient most often is responsible, but in fact, that physician may have no control on the readmission process. For example, a patient with Type 1 diabetes (T1D) with non-healing foot ulcer and peripheral vascular disease is seen most often by an endocrinologist for the management of their diabetes, but due to the foot ulcer the patient is seeing the vascular surgeon/ wound clinic or podiatrist for the condition associated with the admission. These are not physicians listed as the specialties that quarterback. The patient's endocrinologist has no input on the foot ulcer and amputation, particularly if their diabetes is well controlled. This admission would be attributed to the quarterbacking physician, the endocrinologist in this case, which would not be appropriate. Furthermore, Medicare requires that patients on insulin pumps and sensors be seen by an endocrinologist four times per year, which would likely make the endocrinologist the responsible physician, regardless of whether the admission has any connection to their diabetes. **We recommend that the reason for admission should be the primary factor to assign physician responsibility.** We understand that there are numerous exclusions (admission type, diagnosis codes, etc) that are meant to ensure that the admission is attributed to the provider who has the most influence on a patient's chronic conditions. However, a patient may be cared for by multiple specialists and the specialist with the plurality of visits may not always be responsible for the complication for which the patient is being admitted. **Attribution Model** The intent of the measure is to improve quality of care for people with multiple chronic conditions, but retrospective attribution will hamper the ability of providers to improve quality of care for these patients. This attribution model, along with use of administrative data that is not timely, will make it difficult for providers to focus on reduction in admissions if they do not know which patients will be attributed to them. While it would be ideal for the quality improvement efforts to benefit all			

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		patients in a practice, the reality is that most physician practices do not have the time or resources to apply quality improvement efforts to their entire patient population. **Risk Adjustment** We support many of the decision made related to risk adjustment, including inclusion of the AHRQ Socioeconomic Status Index and specialist density as part of the adjustment for social risk factors. However, we believe that social risk factors should be given equal weight in the risk adjustment process as demographic and clinical variables. We note that social risk factors were tested after the assessment of clinical and demographic risk factors. As stated in the report, individual providers often have few resources available and a limited ability to influence health system and community factors to reduce the risk of admission for patients with these social risk factors. Furthermore, providers who feel their MIPS score may be negatively impacted by factors outside of their control may reduce access to care for patients already facing challenges managing their conditions. **Reliability Target** While the minimum reliability score at the TIN level was 0.5 or greater, it would be optimal for CMS to set the reliability target at 0.7 or greater. This change would require that the minimum sample size be set at = or > 62 patients and reduces the number of TINs to which the measure would apply from 45.3% to 23.9%. Even with this change, 81.9% of patients with multiple chronic conditions would still be included in the measure.			
May 24, 2019	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	On behalf of the Heart Failure Society of America (HFSA), we appreciate the opportunity to provide comments on CMS Project: Development and Reevaluation of Outpatient Outcome Measures for the Merit-based Incentive Payment System. HFSA is a multidisciplinary organization working to improve and expand heart failure care through collaboration, education, research, innovation, and advocacy. Our members include physicians, scientists, nurses, nurse practitioners, pharmacists, and patients. Our goal is to significantly reduce the burden of heart failure on patients and families worldwide. We have several concerns we would like to share with you regarding the proposed outcome measure for patients with multiple chronic conditions: 1) The "Buffer Time Frame" of 10 days as noted in the proposal post discharge will be used to define the time for an "unplanned admission" in	Carrie Kovar; Government Relations Consultant; Heart Failure Society of America	carrie@korrisgroup.com	

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		the MCCC cohort of patients. As clinicians who treat the sickest of patients, we believe this time frame should be extended to at least 30 days. 2) We are concerned about the manner of "risk stratification" applied to this patient cohort. One standardized model cannot apply to patients across the country due to a number of factors, including limited financial resources, family support and poor follow-up opportunities, especially for patients in rural or economically disadvantaged areas. We do not believe such factors have been adequately accounted for under the proposed measure. 3) We believe this measure should include a requirement that CMS provide a list of patients that fall into the MCCC patient cohort upon request of a clinician. This would help clarify those patients who the clinicians are responsible for under this metric. 4) We are concerned that this project is governed by rules in place for the ACO model for MCCC patients developed by the CORE Group for the ACO model. The care provided in the ACO model is much more precisely governed for outpatient and inpatient management than in an independent practice model or an integrated health care model comprised of loosely organized groups of practices owned by a larger hospital system with very little true integration of care. Patients have diverse levels of support once discharged to their respective communities and many have care that is poorly coordinated for multiple reasons. Even in the urban centers the PCP's often do not see the patient in the hospital setting and often the treating subspecialist is not consulted when a patient is admitted. In many instances a patient goes to a completely different hospital system and clinicians often do not find out about the admission for some time post discharge. We do not believe this scenario is accounted for in the proposed MIPS model for non ACO physicians. The process of grading physicians in this setting is premature and unfair. 5) We are also concerned about limits on the ability to monitor patients remotely within a given medical community. Communities and patient resources vary to significant degrees across the country, including access to care, family any caregiver support, and socioeconomic resources. These factors often negatively impact the provision of timely follow up care. This is particularly true for patients who live in small rural communities.			

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		6) We believe there should be considerations in this measure for patients with stage D heart failure who are not on hospice, as well as patients on inotropic therapy. Experienced clinicians who care for heart failure patients recognize it is very difficult to effectively manage this patient cohort and keep these patients out of the hospital. Factors include the degree of underlying comorbidities, in particular renal and pulmonary (MCCC cohort), the fact that many patients do not want to "give up" living despite their very poor prognosis, and the fact that they are not candidates for advanced heart failure modalities or therapy and/or may not have access to potential treatments. We appreciate your consideration of our comments.			