

PUBLIC COMMENT VERBATIM REPORT

GENERAL COMMENTS

Table 1. Verbatim Comments: MIPS New Measures—General Comment/Both Measures

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Type of Organization	Response
12/20/2018	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty	<p>The American Medical Association (AMA) appreciates the opportunity to comment on the Hospital-Wide All-Cause Unplanned Readmission (HWR) and Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA/TKA complication) measures for use in the Merit-based Incentive Payment System (MIPS). The AMA strongly believes that the measures must be evidence based, attributed to the appropriate levels where the greatest influence can occur, and proven to be reliable and valid. Based on the information released for public comment, we do not believe that either measure meets those criteria.</p> <p>Key principles driving attribution identification and evaluation</p> <p>The AMA supports many of the principles used to guide the attribution process for both of these measures but we recommend that an additional principle be incorporated. Specifically, attribution must be determined based on the evidence that the accountable unit is able to meaningfully influence the outcome. This principle aligns with the most recent National Quality Forum (NQF) report, Improving Attribution Models.¹ This principle also would support any measures developed by the Centers for Medicare & Medicaid Services (CMS) as they are reviewed during the NQF Consensus Development Process since the evidence requirements for outcome measures now require that there be at least one structure or process that can influence the outcome and this relationship must be demonstrated through empirical evidence.² CMS must begin to demonstrate these relationships with the accountable unit prior to implementing these measures in MIPS. As discussed in our comments on the evidence for each measure below, we do not believe that CMS has adequately demonstrated this link.</p> <p>In addition, we encourage CMS to reconsider Principle #3: Clinician quality reflects hospital quality, as it is very narrowly focused based on the respecification of these two measures and may not be applicable in all circumstances. In addition, this narrow view does not adequately address the nuances and complexities that application of a hospital-specific measure to physicians in the outpatient setting may face. For example, we found it difficult to reasonably apply this principle to the HWR measure given the lack of clear relationships between the primary care provider in the outpatient setting who is attributed the readmission based on retrospective assignment of beneficiaries as no information on how this provider can meaningfully influence readmissions was demonstrated. It is unclear that previous care can be assumed to represent a valid association to the readmission.</p>	James L. Madera, MD Executive Vice President, CEO American Medical Association	Professional Association	Thank you for your comments. Please see Section 1, Summary of Comments Common to Both Measures

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12/20/2018	<p>MIPS Hospital-Wide All-Cause Unplanned Readmission Measure</p> <p>MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty</p>	<p><i>Evidence base to support either measure</i></p> <p>While the AMA agrees that it is useful to understand the rate of complications following THA or TKA and unplanned readmissions particularly for quality improvement, we did not see explicit information outlining how physicians can implement structures or processes that can lead to improved outcomes for these patients. Rather, most of the cited references focused on incidence rates and prevalence of specific risk factors and did not address what factors or processes leveraged by a physician can reduce the occurrence of either outcomes. As CMS continues to expand the types of measures for possible use in MIPS, the underlying evidence used as the basis to attribute a clinical outcome to a specific measured entity, such as, physicians must be established, and we do not believe that CMS has provided sufficient information for either measure to support the attribution to physicians.</p> <p><i>Rigor of scientific acceptability testing and results</i></p> <p>In addition, we were extremely troubled to see that social risk factors were not tested in the risk adjustment models in either measure. The AMA strongly disagrees with the conclusion that because the initial review of the hospital-level measure by NQF did not require the inclusion of these factors, these factors do not need to be re-examined at the physician level. In fact, on review of the Evaluation of the NQF Trial period for Risk Adjustment for Social Risk Factors report,³ it is clear that NQF did not reach a general conclusion that inclusion of social risk factors in risk models was not supported. Rather, the approaches to testing these data should be revised such as multi-level models or testing of social factors prior to 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. We believe that neither measure should be considered for implementation until the need for social risk factors is adequately assessed and the c-statistics are further increased beyond 0.65 for the THA/TKA complication measure and 0.64 for the HWR measure.</p> <p>Decisions on the inclusion of these risk factors in adjustment models must be made based on data and not assumptions. CMS must begin to identify the degree of social risk factors and availability of services for specific patient populations. Strategies such as applying the American Community Survey or a similar data set to determine whether patients for a specific hospital or other provider live in an area where there are fewer resources available should be explored. We readily acknowledge that there are challenges to this type of approach since it requires linkages of patient panels to communities, which may not be the same area where the admission occurred. Nevertheless, these strategies would provide a more comprehensive assessment of the current state and would allow CMS to adjust the measure based on clinical complexity and social risk. The AMA strongly encourages CMS to continue to explore and incorporate additional risk factors and strategies.</p>	<p>James L. Madera, MD</p> <p>Executive Vice President, CEO</p> <p>American Medical Association</p>	Professional Association	Thank you for your comments. Please see Section 1, Summary of Comments Common to Both Measures

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12/20/2018	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty	<p>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, especially when measures are applied to more than one physician. Specifically, we note that while the mean and median signal-to-noise reliability may achieve 0.7, the range when applied to smaller volumes is generally wider than desired. For example, the range when applying the THA/TKA complication measure to eligible clinicians with more than 25 admissions was 0.582 – 0.988 and 0.463 – 0.996 for eligible clinician groups. Higher case minimums should be considered for the THA/TKA complication measure and we support utilizing the higher case minimum of 100 admissions for the HWR measure.</p> <p>Further testing to demonstrate the validity of the measures as it relates to its application to each of the accountable units to which the measure is attributed must be completed such as predictive and construct validity. Face validity is not sufficient, particularly as the survey did not specifically assess the degree to which the experts agreed that the measure attributed to each accountable unit resulted in scores that were valid and useful. In addition, 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.</p> <p>In conclusion, CMS must balance the desire to apply these measures to the broadest number of clinicians 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.</p> <p>The AMA appreciates the opportunity to provide our comments and thanks CMS for considering our views. If you should have any questions regarding this letter, please feel free to contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.</p> <p>1 National Quality Forum. Improving Attribution Models. Final Report. August 31, 2018. Available at: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=88154. Last accessed December 18, 2018.</p> <p>2 National Quality Forum. Measure Evaluation Criteria. September 2018. Available at: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=88439. Last accessed December 18, 2018.</p> <p>3 National Quality Forum. Evaluation of the NQF Trial period for Risk Adjustment for Social Risk Factors. Final report. July 18, 2017. Available at: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=85635. Last accessed December 18, 2018.</p>	James L. Madera, MD Executive Vice President, CEO American Medical Association	Professional Association	Thank you for your comments. Please see Section 1, Summary of Comments Common to Both Measures

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12/21/2018	<p>MIPS Hospital-Wide All-Cause Unplanned Readmission Measure</p> <p>MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty</p>	<p>The PCPI appreciates the opportunity to comment on the draft measures included within the “Development of Inpatient 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.</p> <p>The PCPI would like to comment on the data smoothing and shrinkage techniques described in the documents as methods used to address issues with noise and variance in data. The problem is that when applied to performance results in outcome measures it is difficult for both providers and patients to interpret the results in a meaningful way. This means that it will be challenging for providers to use the data to make change in their clinical practice and for patients to know how to interpret results to determine when good quality care is being provided. Therefore, using these methods for reporting performance - and in turn connecting to payment - will be difficult for providers to accept. The statistical approaches applied to low volume providers need independent review before being applied to these types of measures</p> <p>We also appreciate the concerns regarding case volume and its effect on measure reliability. We understand the methodological considerations that went into the recommendation that the measure applies to Eligible Clinician (EC) groups with at least 25 patients and ECs with at least 25 patients. However, we are concerned that excluding EC groups and ECs solely based on volume dilutes the results and can possibly end up excluding more providers than it includes. As a measurement community, we need to be able to solve the challenges related to low volume providers so that we have a full and comprehensive understanding of the quality of care provided throughout the country. We would recommend that CMS undertake a surveillance activity that allows for an assessment of the complication rates for the EC groups and ECs that are excluded from the measure as a result of volume. This would serve as an intermediate step until further research can be performed that can help address the methodological issue of low volume providers. It can also serve to inform elements of that research.</p>	<p>Beth Bostrom, MPH</p> <p>Project Manager, Measure Specifications</p> <p>Physician Consortium for Performance Improvement</p>	Quality Improvement Organization	Thank you for your comments. Please see Section 1, Summary of Comments Common to Both Measures

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1/4/2019	<p>MIPS Hospital-Wide All-Cause Unplanned Readmission Measure</p> <p>MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty</p>	<p>On behalf of the more than 53,000 members of the American Society of Anesthesiologists® (ASA), I appreciate the opportunity to provide comment on the development of two outcome measures for the inpatient setting for the Merit-based Incentive Payment System (MIPS) assessing Risk-Standardized Complication Rate following Elective Primary Total Hip Arthroplasty and Hospital-wide All-cause Unplanned Readmission. ASA looks forward to continued collaboration and opportunities to comment and participate in measure development activities, including Technical Expert Panels (TEPs), especially those that pertain to anesthesiologists and reflect a shared accountability measure framework.</p> <p><i>ASA supports the development of measures for the inpatient hospital setting for the MIPS Quality component.</i></p> <p>Both measures developed by this CMS Inpatient Outcome Measures Technical Expert Panel (TEP) evaluate critical outcomes for the inpatient hospital setting. Within MIPS, it is increasingly difficult for certain specialties and clinicians working in specific care settings to find an adequate number of measures to report for the Quality component. With many of the measures available in MIPS applying to office-based and primary care settings, development of measures that include clinicians in the perioperative period is a positive step to ensuring all clinicians have adequate measures to report. ASA encourages Yale-CORE and other measure developers to continue exploring measure gaps in the inpatient setting for anesthesiologists and other clinicians that may have a smaller selection of measures from which to choose.</p> <p><i>Yale-CORE should explore opportunities to develop shared accountability measures that include anesthesiologists.</i></p> <p>Anesthesiologists are leaders during the perioperative period and are responsible for assessing and managing patient risks and delivering high-quality care. They must work closely with surgeons and other members of the anesthesia and surgical care teams to ensure positive patient outcomes. Clinical actions and outcomes for surgical patients are often based on shared efforts, for which multiple clinicians from a range of specialties should be accountable. The Risk-Standardized Complication Rate following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty as written is attributed to a single clinician. ASA believes this measure presents an opportunity to demonstrate shared responsibility between surgeons and anesthesiologists for shared outcomes during these procedures. While it may not be feasible to accommodate such a change in the current measure iteration, we encourage Yale-CORE and other developers to explore measures that promote shared accountability and collaboration during the surgical episode.</p>	Alexander A. Hannenberg, M.D., Interim Chief Quality Officer, American Society of Anesthesiologists	Professional Association	Thank you for your comments. Please see Section 1, Summary of Comments Common to Both Measures

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1/4/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty	<p><i>Yale-CORE should consider additional outcome measures that explore other surgical and procedural settings.</i></p> <p>ASA recognizes the importance of measuring unplanned readmission in the Hospital-wide All-cause Unplanned Readmission measure. We support the inclusion of such a measure in MIPS and believe the physicians included in the attribution model are appropriate. ASA encourages Yale-CORE to explore other similar measures for alternative settings. A significant proportion of anesthesiologists practice in Ambulatory Surgical Centers (ASCs) and outpatient centers in some capacity. An additional measure evaluating unplanned admission to hospital or emergency care following outpatient surgery would be an important quality indicator for facilities and the clinicians providing surgical and anesthesia care on an ambulatory basis. Thank you for the opportunity to comment on these measures. ASA believes it is important to develop measures with accountability that is aligned with the way in which actual care is delivered – by multidisciplinary teams collaborating to drive optimal outcomes. We look forward to working together with CORE on measures and other projects in the future.</p>	Alexander A. Hannenberg, M.D., Interim Chief Quality Officer, American Society of Anesthesiologists	Professional Association	Thank you for your comments. Please see Section 1, Summary of Comments Common to Both Measures

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1/4/2019	<p>MIPS Hospital-Wide All-Cause Unplanned Readmission Measure</p> <p>MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty</p>	<p>The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. The FAH appreciates the opportunity to comment on the Hospital-Wide All-Cause Unplanned Readmission (HWR) and Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA/TKA complication) measures for use in the Merit-based Incentive Payment System (MIPS). The FAH strongly advocates that any measure that is proposed for use in payment programs should be evidence-based, appropriate for accountability purposes at the designated level of attribution, and demonstrated to be reliable and valid.</p> <p>Key Principles Driving Attribution Identification and Evaluation</p> <p>The FAH supports many of the principles outlined in both documents guiding re-specification of existing hospital-level measures to attribution at the clinician level but has concerns with Principle #3: Clinician Quality Reflects Hospital Quality. The FAH questions whether this principle can reasonably be implemented more broadly beyond the two measures of current interest, especially when the attribution approach is to apply a measure as broadly as possible. It was particularly challenging to apply this principle to the HWR measure due to the lack of evidence that a primary care provider in the outpatient setting is able to meaningfully influence the outcome – readmissions. The validity of this attribution is unclear when it has not been demonstrated that prior care by this provider is directly associated with influencing the readmission.</p> <p>The FAH strongly believes that CMS and its developer must re-examine the current approach of broad attribution methodologies in the absence of any evidence that clinicians can meaningfully influence the outcome of interest as outlined during the most recent National Quality Forum (NQF) report, Improving Attribution Models.¹ CMS must ensure that attribution to an accountable unit is supported by at least one structure or process that can influence the outcome and this relationship must be demonstrated through empirical evidence. This principle aligns with the 2018 NQF Measure Evaluation Criteria and FAH believes that it must be demonstrated by research and not assumptions prior to implementation of either of these measures.</p> <p>The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. The FAH appreciates the opportunity to comment on the Hospital-Wide All-Cause Unplanned Readmission (HWR) and Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA/TKA complication) measures for use in the Merit-based Incentive Payment System (MIPS). The FAH strongly advocates that any measure that is proposed for use in payment programs should be evidence-based, appropriate for accountability purposes at the designated level of attribution, and demonstrated to be reliable and valid.</p>	Claudia A. Salzberg, Vice President, Quality Federation of American Hospitals	Hospital Association	Thank you for your comments. Please see Section 1, Summary of Comments Common to Both Measures.

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1/4/2019	<p>MIPS Hospital-Wide All-Cause Unplanned Readmission Measure</p> <p>MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty</p>	<p><i>Key Principles Driving Attribution Identification and Evaluation</i></p> <p>The FAH supports many of the principles outlined in both documents guiding re-specification of existing hospital-level measures to attribution at the clinician level but has concerns with Principle #3: Clinician Quality Reflects Hospital Quality. The FAH questions whether this principle can reasonably be implemented more broadly beyond the two measures of current interest, especially when the attribution approach is to apply a measure as broadly as possible. It was particularly challenging to apply this principle to the HWR measure due to the lack of evidence that a primary care provider in the outpatient setting is able to meaningfully influence the outcome – readmissions. The validity of this attribution is unclear when it has not been demonstrated that prior care by this provider is directly associated with influencing the readmission.</p> <p>The FAH strongly believes that CMS and its developer must re-examine the current approach of broad attribution methodologies in the absence of any evidence that clinicians can meaningfully influence the outcome of interest as outlined during the most recent National Quality Forum (NQF) report, Improving Attribution Models.¹ CMS must ensure that attribution to an accountable unit is supported by at least one structure or process that can influence the outcome and this relationship must be demonstrated through empirical evidence. This principle aligns with the 2018 NQF Measure Evaluation Criteria and FAH believes that it must be demonstrated by research and not assumptions prior to implementation of either of these measures.²</p> <p><u>HWR Measure</u></p> <p>The FAH does not support attributing this measure to the three types of clinicians due to the lack of sufficient data and empirical evidence to demonstrate that any of these individuals can meaningfully influence readmission rates. While FAH agrees that this information may be useful for quality improvement purposes, this attribution must be supported by evidence of structures and processes that each clinician can leverage to reduce readmissions. Currently, the literature cited does not address on how readmissions can be attributed to each of the clinician types outlined. CMS and its developers must begin to provide adequate justification for attribution of these outcomes beyond assumptions and general statements that its application is appropriate.</p> <p>In addition, the FAH is troubled by the lack of robust testing of the risk adjustment model for social risk factors and limited testing to demonstrate that the attribution methodologies provide valid representations of the care provided by clinicians. The HWR measure must demonstrate higher levels of signal-to-noise reliability, not just at the mean and median but the minimum and maximum results, which we note was not provided for this measure, and the c-statistic of the models must be increased beyond 0.64.</p>	Claudia A. Salzberg, Vice President, Quality Federation of American Hospitals	Hospital Association	Thank you for your comments. Please see Section 1, Summary of Comments Common to Both Measures.

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1/4/2019	<p>MIPS Hospital-Wide All-Cause Unplanned Readmission Measure</p> <p>MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty</p>	<p>The FAH disagrees with the conclusion that because NQF did not require the inclusion of social risk factors in the hospital-level measure, that same logic can therefore be applied to the clinician-level measure and wonders if CMS and its developer have misinterpreted the conclusions reached by NQF during their trial period for risk adjustment of social risk factors.³ Rather the report called for new and revised approaches to testing these data such as inclusion of social risk factors before clinical factors are analyzed and building multi-level models that may better represent the complexity of these patients and various factors.</p> <p>The FAH believes that some clinical diagnoses and outcomes will be impacted more significantly by social risk factors (e.g., availability of services such as pharmacies and transportation) and it is even more likely for these factors to influence outcomes that extend well past the time of discharge. Measures must be specified to ensure that they produce results that are reliable and valid and enable fair comparisons. By not examining whether any one of these factors should be included, there is increased risk that an entity's true performance will be misrepresented and could provide inaccurate information to patients and their families. FAH strongly urges CMS and its developer to continue to identify new sources that offer more robust data on these factors and be open to new adjustment approaches to better answer the question.</p> <p>The FAH notes that the face validity testing was conducted with the Technical Expert Panel (TEP), whose conclusions may be biased based on their participation in the re-specification of the measure and we encourage CMS to broaden those surveyed beyond this group. In addition, the FAH does not believe that face validity is sufficient testing to demonstrate that the measures as attributed provide appropriate and evidence-based representations of the care provided by these clinicians. We strongly encourage CMS to validate these measures through additional testing such as predictive and construct validity to ensure that application of the measure to each of the accountable units is appropriate and yields scores that are valid and useful.</p> <p>2 National Quality Forum. Measure Evaluation Criteria. September 2018. Available at: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=88439. Last accessed December 18, 2018. 3 National Quality Forum. Evaluation of the NQF Trial period for Risk Adjustment for Social Risk Factors. Final report. July 18, 2017. Available at: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=85635. Last accessed December 18, 2018.</p>	Claudia A. Salzberg, Vice President, Quality Federation of American Hospitals	Hospital Association	Thank you for your comments. Please see Section 1, Summary of Comments Common to Both Measures.

Table 2: Verbatim Comments: MIPS THA/TKA Complication Measure

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Type of Organization	Response
1/4/2019	MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty	<p>Re: General Comments on Small Volume Providers and Attribution</p> <p>Dear CORE Project Team:</p> <p>The Society for Vascular Surgery (SVS), a professional medical society composed of 5,800 specialty-trained vascular surgeons and other medical professionals who are dedicated to the prevention and cure of vascular disease, is pleased to provide comments on the CMS Inpatient MIPS Measures Project. We appreciate this project including the expertise of a vascular surgeon. We understand that general comments on this project will be taken into consideration with future projects regarding adapting claims-based hospital measures to assess the quality of care provided to Medicare beneficiaries by clinicians or clinician groups that are eligible to participate under the Merit-Based Incentive Payment System (MIPS).</p> <p>As with the work that SVS has done regarding episode specific cost measures, we wanted to express concerns regarding the attribution of claims data to individual surgeons for specific patients.</p> <p>SVS is concerned about low volume providers and the attribution methodology that is used for all MIPS measures for these individual physicians and physician practices. We believe that CMS and the CORE Team need to convene a subgroup of this project with the specific charge of understanding and recommending the real number of cases needed for a valid, reliable attribution methodology. In the MIPS cost measures and now with this project, numbers such as 10, 20, and 25 get used, but it is unclear if this is more for convenience or if it is research driven. Physicians need to be measured with their own, specific data for it to be meaningful. Calculating a score for low volume surgeons based on overall Medicare claims data is not meaningful or relevant.</p> <p>Also, SVS urges this CORE Project to examine how actual patient complications can be captured in the Medicare claims data and attributed to individual physicians regardless of the number of complications. A physician seeing their complications data will lead to quality improvement actions being implemented and improvement in patient outcomes being realized.</p> <p>The SVS appreciates the opportunity to provide comments on this CMS Inpatient MIPS Measures Project. If you have any questions or need additional information, please contact Mindi Walker, Director of the SVS Washington Office at MWalker@vascularsociety.org or 202-787-1220.</p>	<p>Karen Woo, MD, Chair; Patrick Ryan, MD, Vice-chair</p> <p>SVS Quality, Performance and Measure Committee,</p> <p>Society for Vascular Surgery</p>	Professional Association	<p>Thank you for your comments. Please see Section 2, Summary of Comments on the MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty Measure</p>

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1/4/2019	MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty	<p>I am writing as Chair of the Academic Hospitalist Committee on behalf of the Society for General Internal Medicine. We polled our members on the Hospital-wide all-cause unplanned readmission and THA/TKA complication measures and the responses we got are compiled here:</p> <p>“Regarding the risk-stratified complication rate, the clinician-level outcome measure has similar limitations as the hospital outcome measure...for example, it would be much more meaningful if PEs and DVTs could be tracked and assessed for the full 30-days after surgery, rather than just counting events that occurred during the index admission or required re-hospitalization. Data has shown that rates during the index admission do not necessarily correlate with post-discharge rates...and the median post-op time for both PEs and DVTs occurs nowadays after the average length of stay. Thus, I doubt orthopedic/hospitalist groups and hospitals would change their VTE prophylaxis protocols based on the MIPS data as outlined.</p> <p>TKA's are no longer on the Inpatient Only (IPO) list. Since some are now being performed on an outpatient basis, it seems like they would not be included in this outcome measure based on actual inpatient admissions. If orthopedists operate on more of their "healthy" patients on an outpatient basis, this would create a sicker inpatient population. As long as CMS's risk adjustment methodology accounts for this, then hopefully the assessment of clinician quality would remain valid.</p> <p>It is unclear to me from reading the proposal how this will impact hospitalist reimbursement for inpatient consults, based on the various potential financial agreements out there. Agree that this would be worth exploring more.”</p>	Matthew Tuck, Chair of the Academic Hospitalist Committee Society for General Internal Medicine	Professional Association	Thank you for your comments. Please see Section 2, Summary of Comments on the MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty Measure
1/3/2019	MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty	<p>I haven't been able to review the details of this complication measure for THA/TKR, but I am concerned about it. How will you ensure complication rates are normalized for complicated patients? If every joint replacement I perform is on a very sick, very complicated patient, will that be reflected in the hospitalization readmission rate?</p> <p>If this is not done properly, the end result is surgeons will cherry pick healthy patients. Since I practice in a low-volume, rural area (3 hours driving time to the nearest high-volume center), this measure will cause me to reconsider performing joint replacements. As we know, high-volume centers cannot perform *all* joint replacements. Some must be done in rural areas or in low-volume centers. If rural areas no longer offered joint replacement, many patients would be forced to drive long distances for pre-op, surgery, and post-op. this would greatly disadvantage rural patients exactly at the time there is an emphasis on improving rural healthcare.</p> <p>I understand the intent, and I do share the goal of decreasing complications. This measure will not produce a reduction in complications, but a shift in where patients have surgery or in what types of patients have surgery.</p>	James Barber, M.D. Southeastern Orthopedics	Individual	Thank you for your comments. Please see Section 2, Summary of Comments on the MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty Measure

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1/4/2019	MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty	<p>Unfortunately, the data base in use continues to be widely considered flawed and inaccurate. Actual chart to review validation, which has only been reported once in NQF 1550 showed up to a 10% misassignment rate even after dropping some forms of complications. There does not appear to have been any further testing at this level, and to adjudge performance across much smaller percentages of average complication rates is a concern, especially with even smaller numbers than used in NQF 1550. This remains a significant challenge to the validity of such administrative data based measures. Such THA/TKA readmission and complication measures do not seem to improve upon prior hospital-specific THA/TKA outcome measures, and continue to have a C-statistic of 0.65, which is considered inadequate. I appreciate that CORE tested SES factors for inclusion and left such factors out of the measure adjustment. Unfortunately, the analysis reaching that conclusion fails to capture the overall community effect of a practice in an urban topology suffering pervasive poverty. The question of validity, poor risk adjustment, and ongoing resistance to SES adjustment puts condition classes of patients at risk for access to care. I appreciate that the analysis showed that the performance of providers is not significantly influenced by the performance of their hospital, but this is not surprising given that most large EC groups dominate the hospitals overall volume.</p> <p><u>Response to specific questions</u></p> <p>1. “Does the measure identify the appropriate EC or EC group responsible for complications following elective primary THA/TKA procedures?”</p> <p>There is concern that larger groups sharing the same TIN will have less variability on the margin than individual practitioners that might suffer from a few outliers any given year; they are in effect, prisoners of small numbers. Conversely, the cut-off at 25 cases for inclusion ignores the reality of a great number of such surgeries are performed by low volume surgeons. Their performance should be captured and at minimum reported collectively to give perspective to the individual practice with 50 – 100 cases a year competing with TIN’s that can exceed a thousand.</p> <p>2. “What, if any, additional validity testing would be meaningful for this measure?”</p> <p>I believe that additional validity testing is necessary at this point. CORE has not taken appropriate steps to test and evaluate the accuracy of the actual records compared to administrative data sets.</p> <p>CORE found the measures performed with a c-statistic of 0.65. This is not ideal and can be improved upon with more orthopedic specific co-morbidities, as reported by Ayers and Fehring. Again, condition classes and socioeconomic classes face possible reduced access to care.</p>	Adolph Yates, MD University of Pittsburgh Medical Center	Individual	Thank you for your comments. Please see Section 2, Summary of Comments on the MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty Measure

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Type of Organization	Response
1/4/2019	MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty	<p>The American Association of Hip and Knee Surgeons (“AAHKS”) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (“CMS”) and the Yale New Haven Health Services Corporation - Center for Outcomes Research and Evaluation (“CORE”) regarding the draft clinician quality measure for complications following elective primary total hip arthroplasty (“THA”) and/or total knee arthroplasty (“TKA”) (hereafter “THA/TKA complication measure”).</p> <p>AAHKS is the foremost national specialty organization of more than 4,000 members with expertise in total joint arthroplasty (“TJA”) procedures. Many of our members conduct research in this area and are experts in using evidence based medicine to better define the risks and benefits of treatments for patients suffering from lower extremity joint conditions. In all of our comments, AAHKS is guided by its three principles:</p> <ul style="list-style-type: none"> * Patient access, especially for high-risk patients, and physician incentives must remain a focus; * Health care reform is most effective when physician-led; and * The burden of excessive physician reporting on metrics detracts from care. <p>AAHKS endorses these measures. Our specific comments are as follows:</p> <p>I. The physician-specific recognition of complications measures for elective primary THA/TKA</p> <p>In conjunction with CMS, CORE conducted a re-specification of the hospital THA/TKA complication and readmission measures for use in MIPS. CORE seeks to develop an Eligible Clinician (“EC”) or EC group level outcome measure that reflects quality of care for patients undergoing elective primary THA/TKA. The measures’ outcomes are any unplanned readmission or one of the specified medical or surgical complications occurring during the index admission or during a readmission except death, which can occur anywhere as long as it is within 30 days of the state of the index admission. The measure is risk-adjusted and patient outcomes are attributed to the clinician who billed for the procedure. EC groups and EC are defined as unique combinations of National Provider Identifier (“NPI”) or Tax Identification Numbers or (“TIN”).</p> <p>We support CMS’ efforts to develop an eligible clinician-level and/or eligible clinician group-level outcome measure that reflects the quality of care for patients undergoing elective THA/TKA procedures. CMS partnership with CORE is a positive step towards accurately evaluate the quality of care provided by MIPS eligible clinicians or clinician groups.</p> <p>AAHKS has long advocated for the development of risk-adjusted physician and group-specific measures for elective THA/TKA procedures. Such THA/TKA readmission and complication measures are a significant improvement over the prior hospital-specific THA/TKA outcome measures and will do much to advance clinician engagement in value-based care. AAHKS has also long advocated</p>	<p>Joshua Kerr, Director of Advocacy and International Activities, American Association of Hip and Knee Surgeons</p>	Professional Association	Thank you for your comments. Please see Section 2, Summary of Comments on the MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty Measure

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Type of Organization	Response
1/4/2019	MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty	<p>for all quality measures to be risk-adjusted, including risk adjustment for socioeconomic status (“SES”). We appreciate that CORE tested SES factors for inclusion and left such factors out of the measure adjustment only after determining that, in this case, the SES factors did not add any new value and were likely otherwise represented by clinical factors.</p> <p>Further, we also appreciate that the analysis showed that the performance of providers is not significantly influenced by the performance of their hospital.</p> <p>II. Response to specific questions</p> <p>1. “Does the measure identify the appropriate EC or EC group responsible for complications following elective primary THA/TKA procedures?”</p> <p>The measure attributes the outcome for each patient to the single clinician who files the Medicare physician claim for the THA/TKA procedure during the initial admission. When patients have multiple claims for a single THA/TKA procedure, an algorithm is used to identify the appropriate EC for attribution. For instance, if there are multiple physician submitting the Medicare claim for the THA/TKA, the algorithm will exclude, for purposes of quality measure attribution, any physicians who were assistants-at-surgery or who are not orthopedic surgeons. In the absence of an identifiable billing surgeon, the measure will default to the Operator as listed on the hospital claim. We believe this is a reasonable and thorough algorithm to identify the surgeon most likely to be mainly responsible for the THA/TKA.</p> <p>We believe the measure as designed will accurately identify the appropriate EC or EC group responsible for complications following elective THA/TKAs. Under the measure as developed by CORE, ECs are identified as unique combinations of NPI and TIN. Patients are attributed to a unique NPI/TIN combination and a single clinician may receive more than one measurement if they submit claims under two or more TINs for different groups. CORE refers to groups of clinicians with the same TIN as MIPS EC groups. While the use of TIN as a group identifier means that MIPS EC groups will only approximately align with actual practice groups, we believe this is the most accurate means technically available to identify and measure physician groups.</p> <p>2. “What, if any, additional validity testing would be meaningful for this measure?”</p> <p>We do not believe additional validity testing is necessary at this point. CORE seems to have taken appropriate steps to test and evaluate various aspects of the measure, as informed by practicing clinical experts.</p> <p>Take, for example, the c-statistic (aka concordance statistic, the indicator of the measure’s ability to correctly classify those patients who have had a complication). CORE found the measures performed with a c-statistic of 0.65. Potential c-statistic values range from 0.50, meaning no better than random chance, to 1.0, an indication of perfect prediction.</p> <p>While 0.65 is not ideal and can be improved upon, we believe that 0.65 represents the likely highest level of accuracy possible to achieve with available administrative claims data. The 0.65 is certainly an improvement over the 0.60 score when the measure was</p>	<p>Joshua Kerr, Director of Advocacy and International Activities, American Association of Hip and Knee Surgeons</p>	Professional Association	<p>Thank you for your comments. Please see Section 2, Summary of Comments on the MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty Measure</p>

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Type of Organization	Response
1/4/2019	MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty	initially developed. So we thank CORE for its work to improve the c-statistic. Further, regarding the accuracy of measurement of clinicians for outcomes within their control, there have been some initial concerns over the possibility that high-performing surgeons could be dragged down by poorly-performing hospitals, and vice versa. However, we understand that this was evaluated and only affected a few surgeons either way, so we deem the risk not significant.	Joshua Kerr, Director of Advocacy and International Activities, American Association of Hip and Knee Surgeons	Professional Association	Thank you for your comments. Please see Section 2, Summary of Comments on the MIPS Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty Measure

Table 3: Verbatim Comments: MIPS HWR Measure

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Type of Organization	Response
12/3/2018	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>One of the problems we have seen is that since all advanced practice providers (NP/PA) are classified as primary care, that patients get assigned to outpatient provider who is really not their PCP (i.e. saw ortho APP 3 times and real PCP 2 times, but gets attributed to the APP). Is this corrected in this measure?</p> <p>Hospitalists complain that often the DC provider just took care of them day of discharge only and shouldn't be dinged for the readmission.</p> <p>what if surgeon had seen 12/12 days, but hospitalists were the primary providers but 3 different ones so each billed 3/12 and it was a medical issue that results in readmission? Does the surgeon get dinged?</p> <p>Will the cases be named for the EC? I do 45 hospitalist days a year and would like to sort out the readmissions of people I cared for in the hospital vs me as PCP responsible for follow up and continuity of care.</p>	<p>Michael Temporal, MD</p> <p>The CMS QPP Clinician Champions Program</p>	A focus group of volunteer clinicians championing the Quality Payment Program in their communities of practice	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure
12/3/2018	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>As an outpatient clinician, Discharge Summaries are sometimes a bane. The last DC summary I received contained a list of diagnoses, an admission history and physical, some labs and imaging reports (No echocardiogram report), a list of discharge meds, and no description of the 5-day confinement. I like the idea of spreading attribution to include inpatient clinicians if this is accompanied by accountability. Otherwise transitions of care suffer, and readmissions might increase.</p> <p>Often hospitalists work on a 2-week on/off schedule. Depending on where in the schedule the turnover of providers occurs, the hospitalists with the plurality of visits may not have been involved during a the most active/critical period of the hospitalization.</p> <p>Does the inpatient provider fall under facility reporting? That's what it sounds like from the provided material.</p> <p>Michael, to me, this should be a shared thing, since the discharging hospitalist is responsible for the transition, after all. Not necessarily fair, but the 99238/9 codes pay higher.</p> <p>In Honolulu, surgeons almost never are the attending physician. How about in other areas?</p> <p>Please also provide us with more detail on Risk-Adjust Readmission Rates for this measure. One would think that readmission rates might be related to risk adjustment.</p>	<p>Roger Kimura, MD</p> <p>The CMS QPP Clinician Champions Program</p>	A focus group of volunteer clinicians championing the Quality Payment Program in their communities of practice	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Type of Organization	Response
12/3/2018	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	If same physician play 2-3 of the roles, how do we make sure that readmission is not counted 2-3 times against that physician?	Deepanshu Garg, MD The CMS QPP Clinician Champions Program	A focus group of volunteer clinicians championing the Quality Payment Program in their communities of practice	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure
12/3/2018	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	It is quite difficult to track especially when more than one hospital system is involved as well as hospitalist and the true usual provider of care.	Karen Smith, MD The CMS QPP Clinician Champions Program	A focus group of volunteer clinicians championing the Quality Payment Program in their communities of practice	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure
12/3/2018	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	I think the shared attribution applies pressure/incentive for improved care coordination and communication. The challenge is always being able to appropriately design and resource tactics that are effective in addressing the intent of the measure, reducing readmissions. Look forward to discussing further!	Jeffery Lawrence, MD The CMS QPP Clinician Champions Program	A focus group of volunteer clinicians championing the Quality Payment Program in their communities of practice	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Type of Organization	Response
12/4/2018	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>As discussed last evening during the Clinical Champions conference call, the concern for intensity of treatment and multiple conditions still is significant. As mentioned, the “mean” illness over time will decrease out lying illness or complications. However, the issue with smaller, especially Medicare prominent inpatient use, will become unfairly discounted for these excessive costs.</p> <p>Smaller community providers, with just over the 25 patient limit with an individual provider status or a TIN with small numbers would become over scrutinized by these patients. Smaller communities have sicker population, less consulted by specialty as an outpatient, and have poor outpatient attendance to clinic visits. Therefore, a community population quotient, or hospital size variable is recommended. Hospitals with 500 beds and thousands of patients will not need these considerations. Due to these issues above, I encourage you to consider not planning your decision for the larger institution but for the unforeseen consequences of your decision.</p>	Roger Wells, PA-C The CMS QPP Clinician Champions Program	A focus group of volunteer clinicians championing the Quality Payment Program in their communities of practice	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure
12/17/18	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>Escambia county in Pensacola Florida is the second poorest county in the state of Florida. Escambia County measures lower than the state of Florida on all counts of income including per capita personal income, average weekly wage and median household income ("Florida Department of Health: Escambia County," 2013). Pensacola Florida also has the highest percentage of poverty in the state of Florida. According to the 2016 community health assessment of Escambia county the primary health concerns to be tobacco use, healthy weight, access to healthcare, infant mortality, and sexually transmitted disease. Out of the 167 indicators, Escambia County performed worse than the state in 98 of them and half of those show a worsening trend ("Escambia County," 2016). There are multiple factors in which determine a person’s health besides access to healthcare. Eighty percent of our health is significantly determined among poverty, education, race, community culture/infrastructure/policies, and personal choices (smoking, sedentary lifestyle, poor nutrition, obesity, risky sexual behaviors). Only about twenty percent of our health is dependent on access to healthcare. I am responding to this specific topic, to adapt claims-based hospital measures to assess the quality of care provided to Medicare beneficiaries by clinicians or clinician groups who are eligible to participate under the Merit-based Incentive Payment System (MIPS), because I believe CMS is setting healthcare up for failure. I have seen first-hand physicians try all they can to help the patient with education, brochures, exempling, and hours and hours of reiterating information on what to do when the patients are discharged and what will happen if they do not comply just to see a patient return back into the hospital. I understand the providers have a lot of responsibility to make these people well. Sometimes, the clinicians can educate and inform until they are blue in the face. These patients are non-compliant and will return in a matter of hours. I do not believe the stress of the measures should be placed completely on the shoulder of the clinicians. There needs to be a better measuring tool provide incentive-based programs to healthcare providers.</p> <p>Reference:</p> <p>Community Health Needs Assessment 2016. (2016). Retrieved from http://escambia.floridahealth.gov/programs-and-services/community-healthstatus/_documents/partnership_2016_chna_report.pdf</p>	Aubri Velez	Individual	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Type of Organization	Response
1/3/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>On behalf of the American Academy of Family Physicians (AAFP), which represents 131,400 family physicians and medical students across the country, I offer the following comments to the “Hospital-Wide All-Cause Unplanned Readmission Measure” (HWR) for MIPS.</p> <p>1. Does the measure identify the appropriate eligible clinicians or groups responsible for 30-day unplanned readmissions following discharge from an acute care setting? Explain.</p> <p>AAFP Response: We agree that the method of attribution of the existing HWR/ACR measures needed improvement when applied to clinicians, and we are encouraged by CMS’s attempts to address measure weaknesses. We agree that the primary inpatient care provider and the outpatient primary care provider share responsibility for care of the patient and avoidance of readmissions, which are costly and undesirable for the patient. We are concerned, however, with potential unintended consequences of attributing the patient to the discharging physician. For physicians that are covering call for their colleagues, the responsibility for discharge may fall on them. On-call physicians may hesitate to discharge patients to avoid attribution of a patient for whom they had little interaction. This in turn may lead to longer hospital stays, particularly on weekends. This unintended consequence needs to be considered. The AAFP suggests removing the discharging physician from the attribution model.</p> <p>2. Do you agree with the recommendation to report this measure at the level of eligible clinician groups with at least 100 patients in this measure?</p> <p>AAFP Response: We agree the measure should not be applied to individual clinicians due to the reasons cited in the report (i.e., low number of clinicians reach the minimum case volume and a low percentage of patients were represented to reach a reliability of 0.40). However, we are not convinced that 0.40 is an acceptable value for test-retest reliability, even at the group level. We cite the following: “We suggest that ICC values less than 0.5 are indicative of poor reliability, values between 0.5 and 0.75 indicate 12/19/2018 4 of 5 moderate reliability, values between 0.75 and 0.9 indicate good reliability, and values greater than 0.9 indicate excellent reliability.” (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4913118/). Other sources that discuss the need for higher reliability values include: http://ericae.net/ft/pug/reliabil.txt; https://www.nap.edu/read/1862/chapter/8 .</p> <p>We point out that a measure may be reliable, but not valid. A measure cannot be valid unless it is reliable. Reliability is necessary, but not a sufficient condition of validity. Reliability must not be overlooked solely to retain the ability to measure, particularly when measures are used for public accountability and payment.</p> <p>3. What, if any, additional validity testing would be meaningful for this measure?</p> <p>AAFP Response: We would be interested in knowing the reasons why 30% of the TEP members did not agree that the scores were valid and useful—were the members able to identify specific flaws in the cases that were attributed, or was their disagreement more general in nature?</p>	Sandy Pogones, MPA, CPHQ Senior Strategist Health Care Quality Practice Advancement, American Academy of Family Physicians	Professional Association	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure.

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Type of Organization	Response
1/3/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>Risk Adjustment for SES: We agree that SES may reflect differences in quality of care provided to persons with different SES, and we must not be satisfied with a 2-tiered system of health care that delivers poorer care to lower SES patients. However, we continue to believe, supported by the literature, that differences in SES may lead to poorer outcomes that are not related to the quality of care provided. We believe this conflict must be resolved through further testing and analysis to avoid penalizing clinicians that serve low SES patients. Access to care due to lack of insurance, high deductibles, lack of transportation, poor housing conditions, poor nutrition, and other factors are known to impact health outcomes.</p> <p>We thank Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (CORE) for this opportunity to comment on the proposed measures and welcome future opportunities to work together to improve outcomes of care.</p>	<p>Sandy Pogones, MPA, CPHQ Senior Strategist Health Care Quality Practice Advancement, American Academy of Family Physicians</p>	Professional Association	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure
1/3/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>To whom it may concern:</p> <p>The American Academy of Neurology (AAN) appreciates the opportunity to comment on the Yale CORE Hospital-Wide All-Cause Unplanned Readmission Measure. The AAN is the world’s largest medical specialty society representing more than 34,000 neurologists and clinical neuroscience professionals. The AAN is dedicated to promoting the highest quality patient-centered neurologic care. A neurologist is a physician with specialized training in diagnosing, treating, and managing disorders of the brain and nervous system. These disorders affect one in six people and include conditions such as multiple sclerosis (MS), Alzheimer’s disease, Parkinson’s disease, stroke, migraine, epilepsy, traumatic brain injury, ALS, and spinal muscular atrophy. The AAN believes there may be additional exceptions and/or exclusions that should be applied to this measure for patients with neurologic conditions. Some planned readmissions for epilepsy surgery or intracerebral electrodes are not included in the list of planned readmissions. The AAN suggests the following revisions to Table PR.4 and PR.3.</p> <p>Exclude the following diagnoses:</p> <ul style="list-style-type: none"> •Local-rel (focal) (partial) Symptomatic Epilepsy & Epileptic Syndromes w/ Complex Part •Local-rel (focal) (partial) Symptomatic Epilepsy & Epileptic Syndromes w/ Simple Part •Epileptic Spasms, Not Intractable, Without Status Epilepticus <p>Include the following as planned procedures:</p> <ul style="list-style-type: none"> • Insertion of Monitoring Device into Brain, Open Approach 	<p>Erin E. Lee Program Manager, Measure Development American Academy of Neurology (AAN)</p>	Professional Association	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Type of Organization	Response
1/3/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<ul style="list-style-type: none"> •Carotid endarterectomy or other carotid revascularization following transient ischemic attack or stroke (when it doesn't occur during hospitalization) •Induction therapy for autoimmune diseases with rituximab or eculizumab (when not done as outpatient). Autoimmune diseases include neuromyelitis optica, autoimmune encephalitis, multiple sclerosis, myasthenia gravis, chronic inflammatory demyelinating polyneuropathy, and possibly others. <p>Thank you for the opportunity to review and comment on this important measure.</p>	Erin E. Lee Program Manager, Measure Development American Academy of Neurology (AAN)	Professional Association	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure
1/4/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>Dear Inpatient Outcome Measures for the MIPS Development Team:</p> <p>The Society of Hospital Medicine (SHM), on behalf of the nation's hospitalists, is pleased to provide comments on the draft Hospital-Wide All-Cause Unplanned Readmission Measure (HWR Measure) as specified for reporting under the Merit-based Incentive Payment System (MIPS). The HWR Measure was reviewed by SHM's Performance Measurement and Reporting Committee, a group consisting of practicing hospitalists and hospitalist leaders who are experts in measurement and assessment.</p> <p>Hospitalists specialize in providing care to the nation's hospitalized patients and are the front-line providers in America's hospitals. They have a unique position in the healthcare system, having a hand in the performance of both the individual physician-level and hospital-level performance agendas. As such, hospitalists have a longstanding relationship with the hospital-level readmissions measures. Our comments on the HWR Measure are informed by this experience.</p> <p>Attribution</p> <p>The HWR Measure uses a novel attribution methodology to assign a single readmission case to up-to-three providers. Hospitalists are very likely to be a majority of the discharging and primary inpatient care clinicians. A multi-attribution approach encourages team-based care and prioritizes handoffs between providers during hospitalization and at discharge. SHM broadly supports a multi-attribution methodology.</p> <p>We believe it is important for outpatient providers to be engaged with this measure, as handoffs to and patient follow-up with outpatient providers are critical to reducing unplanned readmissions. As structured, the measure would attribute cases to the</p>	Gregory B. Seymann, MD, SFHM Chair, Performance Measurement and Reporting Committee Society of Hospital Medicine	Hospital Association	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Type of Organization	Response
1/4/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>primary care provider who provides the plurality of primary care services over the 12 months prior to the admission, with precedence given to primary care specialties. Many patients may see specialists in a primary care role, particularly those that are dealing with chronic conditions or conditions like cancer. These specialists may also be more clinically relevant to the hospitalization and therefore more appropriate for follow-up post-discharge. We encourage the measure development team to reevaluate whether a specialty-neutral approach to the outpatient attribution may encompass more relevant patient-provider relationships. For example, in patients with readmission for CHF, a large proportion of unplanned readmissions, attribution to the patient's cardiologist may better target providers involved in the post-discharge care of the patient.</p> <p>We acknowledge the discussion in Appendix D.4 Excluded Attribution Rules about why the Outpatient PCP+ approach was not used. However, we believe the clinicians who are attributed cases in this measure should be relevant to the patient's needs at the time of discharge. These may be primary care providers or may be specialists. The current attribution methodology prioritizes only primary care providers. As such, the Outpatient PCP+ may be more appropriate. Another potential approach for attributing outpatient providers to cases may be to look at the plurality of outpatient Evaluation & Management (E&M) services billed in the readmission window.</p> <p>Group Reporting</p> <p>The Measure Methodology Report for Public Comment contains a recommendation for the measure to be reported at the level of eligible clinician groups with at least 100 patients in the measure. We are broadly supportive of this measure being used for group-level reporting, particularly as the analysis shows that few eligible clinicians (about 0.7%) have 200 cases to meet the minimal value of test-retest reliability. We also note that group-level reporting further encourages team-based care and shared accountability. Given that group level reporting can meet minimal test-retest reliability with 100 cases, we support the recommendation for group level reporting with at least 100 patients.</p> <p>We are concerned with the relatively low number of eligible clinician groups who meet the 100-admission threshold. According to the analysis in Table 19, only 14.1% of eligible clinician groups meet or exceed that threshold, despite including more than 96% of patients. While the measure may be reliable at that volume cutoff and include nearly all patients, it does exclude a large number of potentially eligible provider groups. We encourage CMS and the measure development team to consider strategies for future measures and measure specifications that include more clinicians and clinician groups.</p> <p>We disagree with using 30 day as a window for measuring readmissions and encourage the measure development team to consider implementing a shorter readmission period. Recent research indicates that a shorter readmission window, such as 7 days, may be</p>	<p>Gregory B. Seymann, MD, SFHM Chair, Performance Measurement and Reporting Committee</p> <p>Society of Hospital Medicine</p>	Hospital Association	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Type of Organization	Response
1/4/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>more reflective of between-hospital variation in performance.¹ The shorter window may also be more reflective of the impact of discharge care coordination and follow-up,</p> <p>while a longer window incorporates confounding external factors, such as patient social and community impacts, which are beyond the providers’ or hospitals’ control.</p> <p>We believe a readmission measure should target the impact of the hospital and clinicians associated with the hospital stay, discharge process and post-discharge follow-up. Performance assessment should be focused on the areas in which providers have actual influence or direct control. A narrowed readmission window may provide the most effective means to detect true variations in actionable data, providing a better opportunity to develop effective solutions to reduce preventable readmissions. It may also provide more meaningful information to patients about the discharge and post-discharge work of a hospital, inpatient clinicians, and outpatient partners.</p> <p>SHM appreciates the opportunity to provide feedback on the HWR Measure as it continues to undergo development and testing. If you have any questions or we can provide more information, please contact Josh Boswell, Director of Government Relations, at jboswell@hospitalmedicine.org.</p>	<p>Gregory B. Seymann, MD, SFHM Chair, Performance Measurement and Reporting Committee</p> <p>Society of Hospital Medicine</p>	Hospital Association	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure
1/4/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>The American Society of Clinical Oncology (ASCO) appreciates the opportunity to comment on the Hospital-Wide All-Cause Unplanned Readmission (HWR) measure proposed for use in the Merit-based Incentive Payment System (MIPS). 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.</p> <p>Background</p> <p>In 2017, the Centers for Medicare & Medicaid Services contracted with Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE) to adapt its existing hospital-level measure, “Hospital-wide All-cause Unplanned Readmission Measure,” (“HWR”), which is currently publicly reported, for use in assessing individual eligible clinicians or groups of eligible clinicians participating in the Merit-based Incentive Payment System (MIPS).</p> <p>The outcome is readmission within 30 days of discharge from an admission; planned readmissions are excluded. In the measure proposed, each admission is attributed to up to three eligible clinicians or eligible clinician groups:</p> <p>1. The eligible clinician who filed a claim for the ‘discharge procedure’ for the patient; and/or</p>	<p>Karen Hagerty, MD Associate Director, Quality & HIT Policy</p> <p>Policy and Advocacy</p> <p>American Society of Clinical Oncology</p>	Professional Association	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure

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1/4/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>2. The eligible clinician who, during the inpatient stay, billed the most patient-facing charges (may also be the discharge clinician); and/or</p> <p>3. The eligible clinician who provided the plurality of outpatient primary care during the 12 months prior to the admission, as measured by plurality of primary care services.</p> <p>The Measure Methodology Report notes that here, precedence is given to primary care specialties because if it were not, this measure more often identified specialties that were unlikely to be responsible for admission decisions.</p> <p>All admissions assigned to an eligible clinician would be used to construct a single measure score for that clinician, regardless of the reason the admission was attributed. The measure has also been tested for eligible clinician groups (eligible clinicians using the same Taxpayer Identification Number [TIN]).</p> <p>From the cohort, the following admissions are excluded: admissions with insufficient data for risk adjustment, admissions for patients who leave against medical advice, admissions for medical cancer treatment or for conditions that are not typically cared for in short-stay acute care hospitals, and admissions to PPS-exempt cancer hospitals.</p> <p>ASCO Comments</p> <p>This adapted measure is intended for use in MIPS, part of the Quality Payment Program, to assess the performance of eligible clinicians (ECs) or EC groups. There is currently a version of the hospital-level HWR measure in use under MIPS, referred to as the All-Cause Readmission (ACR) measure. The Report states that, where relevant, this measure was drawn from the ACR measure; however, the original hospital-level measure was used as the foundation for this development work because that version has been most rigorously tested and vetted. Measure development work focused on redefining the attribution approach for an EC-or EC group-level measure. We are concerned that while the original ACR measure was attributed only to groups of more than 15 clinicians who also had 200 or more readmissions (“case minimums”), the HWR measure would be attributed to smaller groups and individual ECs with a case minimum of only 100. Further reliability and validity testing is needed prior to implementing this measure across MIPS.</p> <p>The Measure Methodology Report states that the existing hospital-level HWR measure “provides a broad assessment of the quality of care at hospitals, reflects in part the quality of clinician care in the hospital, in that inpatient clinicians are integral to inpatient care and the transition to an outpatient setting. This measure also may reflect the quality of primary care, in that primary care clinicians may influence whether patients return to an acute care setting. It is thus meaningful to adapt the hospital-level hospital-wide, all-cause readmission measure for use in assessing the quality of individual clinician or clinician group care.” ASCO is concerned that this adaptation of a hospital-based measure that reflects “in part” the quality of clinician care and also “may reflect” the quality of primary care lacks the specificity required not only for accurate attribution to individual clinicians but also a</p>	Karen Hagerty, MD Associate Director, Quality & HIT Policy Policy and Advocacy American Society of Clinical Oncology	Professional Association	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure

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1/4/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>demonstrated link between measure results reported to the clinician and subsequent meaningful action by the clinician. In addition--as with earlier cost measures ASCO has commented on--we remain concerned about the attribution of the same outcome to multiple clinicians, as this methodology muddies the true picture on the quality of patient care and thus any individual clinician's ability to interpret and attempt to act upon the reported data.</p> <p>It is our understanding also that social risk factors were not considered in the risk adjustment model for this measure; we have previously commented that these risk factors should be an important part of any risk model and would urge CMS to delay implementation of this measure until such factors can be incorporated, with an allowance for stakeholder input.</p> <p>We appreciate the opportunity to submit comments on this Measure Methodology Report and would welcome further dialog with CMS concerning this or other measures in the Quality Payment Program.</p>	<p>Karen Hagerty, MD Associate Director, Quality & HIT Policy Policy and Advocacy American Society of Clinical Oncology</p>	Professional Association	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure
1/4/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>Problem: Patients with medically refractory epilepsy readmitted for planned epilepsy surgery after a recent (30 days or less) pre-surgical evaluation in the hospital are being counted as 'unplanned readmissions.'</p> <p>Cleveland Clinic (CC) is a not-for-profit, integrated healthcare system dedicated to patient care, teaching, and research. Our health system is comprised of a main campus, 10 community hospitals, and 21 family health centers with over 3,500 salaried physicians and scientists. Last year, our system had more than seven million patient visits and over 220,000 hospital admissions.</p> <p>Cleveland Clinic's comments address the re-specification of the Hospital-Wide All-Cause Unplanned Readmission Measure (HWR measure). Specifically, we would like to recommend changes in the CMS Planned Readmission Algorithm with regard to epilepsy patients.</p> <p>Currently, patients coming back electively to the hospital for epilepsy surgery (either definitive surgery or for intracranial monitoring) within 30 days of an index admission to be monitored or evaluated for surgery are being considered "Unplanned Readmissions" by the CMS algorithm. In order to provide timely treatment and surgery, specialized epilepsy centers need to be able to bring patients back earlier than 30 days for their planned admission. This is important for quality of life, patient care needs, and patient satisfaction. Delayed recognition of seizure or treatment can increase a patient's risk of additional seizures, injury, disability, brain damage, and even early death.</p> <p>Currently, there are specific epilepsy procedures that are not included on the Table PR.3 CMS algorithm for planned procedures.</p> <p>Principle procedures considered unplanned 30 day all-cause readmission:</p> <p>'4A10X4Z' Monitoring Of Central Nervous Electrical Activity, External Approach</p> <p>'00H032Z' Insertion of Monitoring Device into Brain, Pere Approach</p>	<p>Ahsan Moosa Naduvil Valappil, MD Quality Improvement Officer, Epilepsy Center The Cleveland Clinic</p>	Health System	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure

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1/4/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>'00H002Z' Insertion of Monitoring Device into Brain, Open Approach</p> <p>There are also certain epilepsy diagnosis codes that are listed on the Table PR.4 CMS algorithm because they are considered acute diagnoses.</p> <p>Principle diagnoses considered unplanned 30 day all-cause readmission:</p> <p>'G40101' Local-rel symptc epi w simp part seiz, not ntrct, w stat epi</p> <p>'G40109' Local-rel symptc epi w simp prt seiz,not ntrct, w/o stat epi</p> <p>'G40111' Local-rel symptc epi w simple part seiz, ntrct, w stat epi</p> <p>'G40119' Local-rel symptc epi w simple part seiz, ntrct, w/o stat epi</p> <p>'G40201' Local-rel symptc epi w cmplx prt seiz, not ntrct, w stat epi</p> <p>'G40209' Local-rel symptc epi w cmplx prt seiz,not ntrct,w/o stat epi</p> <p>'G40211' Local-rel symptc epi w cmplx partial seiz, ntrct, w stat epi</p> <p>'G40219' Local-rel symptc epi w cmplx part seiz, ntrct, w/o stat epi</p> <p>'G40811' Lennox-Gastaut syndrome, not intractable, w stat epi</p> <p>'G40812' Lennox-Gastaut syndrome, not intractable, w/o stat epi</p> <p>'G40813' Lennox-Gastaut syndrome, intractable, w status epilepticus</p> <p>'G40814' Lennox-Gastaut syndrome, intractable, w/o status epilepticus</p> <p>'G40821' Epileptic spasms, not intractable, with status epilepticus</p> <p>'G40822' Epileptic spasms, not intractable, w/o status epilepticus</p> <p>'G40823' Epileptic spasms, intractable, with status epilepticus</p> <p>'G40824' Epileptic spasms, intractable, without status epilepticus</p> <p>'G40901' Epilepsy, unsp, not intractable, with status epilepticus</p>	<p>Ahsan Moosa Naduvil Valappil, MD</p> <p>Quality Improvement Officer, Epilepsy Center</p> <p>The Cleveland Clinic</p>	Health System	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Type of Organization	Response
1/4/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>'G40909' Epilepsy, unsp, not intractable, without status epilepticus</p> <p>'G40911' Epilepsy, unspecified, intractable, with status epilepticus</p> <p>'G40919' Epilepsy, unsp, intractable, without status epilepticus</p> <p>We strive very hard to provide the highest quality of care for our patients. We ask for consideration of the importance of managing this chronic condition in a timely way. We request that you allow specialized epilepsy centers the ability to admit patients for planned monitoring within 30 days of an index admission without the penalty of the case qualifying as a readmission. Please consider adding the procedure codes listed above to Table PR.3 and excluding the diagnosis codes listed above from Table PR.4.</p> <p>Thank you for conducting a thoughtful process that allows us to provide input on such important issues and for your consideration of this information. Should you need any further information, please don't hesitate to contact me.</p>	<p>Ahsan Moosa Naduvil Valappil, MD</p> <p>Quality Improvement Officer, Epilepsy Center</p> <p>The Cleveland Clinic</p>	Health System	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure
1/4/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Clinician and Clinician Group Hospital-wide All-cause Unplanned Readmission (HWR) Measure for purposes of assessing performance in the Merit-based Incentive Payment System (MIPS). The College is the largest medical specialty organization and second-largest physician group in the United States. ACP members include 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.</p> <p>The College recognizes the importance of holding practices accountable for patient outcomes within their control and ensuring effective transitional care management, which is critical to improving patient outcomes. We appreciate the Centers for Medicare & Medicaid Services (CMS) being responsive to prior concerns raised by ACP and other stakeholders regarding flawed iterations of 30-day hospital readmission measures by making several improvements, particularly related to attribution and risk-adjustment. We value the Agency's ongoing commitment to soliciting stakeholder feedback throughout the development process, including conducting a technical expert panel and offering this public comment period.</p> <p>However, the College firmly believes that all measures used to impact physician payments based on quality and cost performance must be appropriately attributed and risk-adjusted, evidence-based, clinically relevant, and statistically reliable and valid. We do not believe the HWR measure meets this standard and therefore we cannot support it in its current form.</p> <p><u>Patient Attribution</u></p> <p>ACP continues to have concerns about the appropriateness of attributing patients at the clinician level, particularly primary care clinicians. This aligns with the primary concern voiced by respondents who disagreed that the measure was valid and useful.</p> <p>The College urges CMS to prove through a robust evidence-based analysis that this measure can be evaluated at the clinician level while meeting stringent validity and reliability standards. If this cannot be proven or completed in time for implementation, we</p>	<p>Jacqueline W. Fincher, MD, MACP</p> <p>Chair, Medical Practice and Quality Committee</p> <p>American College of Physicians</p>	Professional Association	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure

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1/4/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>encourage CMS to evaluate this measure at the Tax Identification Number (TIN)-level and apply the resulting score to eligible clinicians wishing to be scored individually. Attributing this measure at the clinician level would result in small sample sizes that would be subject to large swings in performance and low levels of reliability and validity. The development data showed that individual clinicians had a wider range of average risk-adjusted readmission rates (RARRs) when compared to groups and were more likely to perform statistically significantly better or worse than the national observed readmission rate. Applying the measure at the TIN-level would result in a larger patient population which helps to ensure higher reliability, support team-based care and support the Center for Outcomes Research & Evaluation (CORE) team’s principle goal to align closely with hospital-level measures, which are measured at the facility level. CMS could also help to mitigate low-reliability at both levels by increasing the case minimum threshold. Attributing admissions to primary care clinicians based on the index admission rather than the readmission is an improvement over past methodologies but does nothing to address the underlying concerns over the inherent validity of evaluating this type of measure at the individual clinician level.</p> <p>There was no evidence provided that primary care clinicians who deliver the plurality of services in the year leading up to the initial admission have sufficient control over readmissions. All measures, especially those tied to payment, must be evidence-based and attributed to the appropriate unit of analysis e.g. where the measure addresses an outcome that is under the influence of the clinician being assessed. This is precisely why the National Quality Forum (NQF) requires as part of its measure evaluation criteria that for any outcome measure, at least one structure or process must influence the outcome and this relationship must be demonstrated through empirical evidence. While this report acknowledges that certainly primary care providers may have some influence over hospital admissions or readmissions, it provides little evidence to substantiate the claim that readmissions are statistically significantly influenced by the primary care services that a patient received in the year leading up to an initial admission. The CORE team acknowledges as much when it says in its report that “inpatient outcomes may be most reasonable attributed to inpatient clinicians.”</p> <p><u>Reliability</u></p> <p>As reiterated previously, any reliability rating below a 0.75, which is considered the minimum for “good” reliability by statisticians, should be unacceptable for any quality or utilization measure. We urge a case minimum of no fewer than 100 patients, as recommended by the CORE team. To further increase reliability, we urge CMS to consider a higher case minimum such as 200 patients, which was used for a similar readmissions measure for the Value-Based Payment Modifier. Finalizing the policies as proposed would lead to unreliable measures, particularly for groups that are small and/or serving rural communities. Measure validity and reliability should never be sacrificed in the interest of adopting more measures or applying measures to more clinicians. CMS should independently set rigorous, consistent standards for reliability and validity against which all future measures will be evaluated.</p>	Jacqueline W. Fincher, MD, MACP Chair, Medical Practice and Quality Committee American College of Physicians	Professional Association	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure

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1/4/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p><u>Risk-Adjustment</u></p> <p>Additional refinements are needed to the risk adjustment methodology to evaluate physicians accurately and mitigate a host of potential unintended consequences, including patient cherry-picking and access to care. In addition to adjusting for case mix, CMS should consider accounting for the total number of conditions each patient has, which has been proven to impact outcomes. CMS recently finalized this as part of the risk adjustment mechanism for Medicare Advantage contracts in the final 2019 Medicare Advantage Rate Notice and Call Letter. This is a positive change that will better account for the expertise and risk inherent to caring for more complex patients. We support this policy for Medicare Advantage beneficiaries and urge CMS to extend it to traditional Medicare beneficiaries.</p> <p>By not properly accounting for a host of geographic and social risk factors, CMS risks inappropriately penalizing physicians who treat some of the most vulnerable patient populations, which could further restrict access for these already at-risk patients. As ACP has stressed in previous research, there is a huge chasm in current quality and cost risk adjustment methodologies for geographic and social risk factors that have been proven to significantly impact quality and cost outcomes, including distance from the nearest hospital or specialist or socioeconomic status. The shortsighted explanation provided in the report that the association between socioeconomic status and health outcomes “is due, in part, to differences in the quality of care that groups of patients with varying socioeconomic status receive” does not begin to account for the host of confounding variables beyond a physician’s control, including access to transportation to make medical appointments, ability to afford critical medications, etc. It is paramount that CMS expediently test, study, and more adequately account for the impact that geographic and social risk factors before finalizing this or any additional measures.</p> <p><u>Testing and Implementation</u></p> <p>The unplanned hospital readmission measure requires further development and testing to ensure its validity and reliability, particularly in relation to primary care physicians, before it can be responsibly implemented and applied to a clinician’s MIPS score. Any measure should not be used to directly impact physician payment in any way before it can be proven to be a predictable, reliable and accurate indicator of true quality and cost performance and does not unfairly penalize physicians for outcomes outside of their control.</p> <p>Once this measure has been revised to meet rigorous validity and evidence-based standards, we encourage CMS to allow for a period of voluntary reporting during which clinicians would receive feedback related to their performance on this measure, but would not have their MIPS scores adversely impacted. This would allow an opportunity for physicians to familiarize themselves with the measure and for CMS to gather more data to affirm the accuracy of this measure and further refine it if necessary before it impacts physician payment. Given the current reporting, feedback, and payment adjustment cycle occurs over a two-year timespan, we recommend the measure be available for testing but not impact payment for at least two years to allow for at least one round of performance feedback before clinicians are evaluated.</p>	Jacqueline W. Fincher, MD, MACP Chair, Medical Practice and Quality Committee American College of Physicians	Professional Association	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Type of Organization	Response
1/4/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	<p>CMS should not move forward with finalizing any new utilization measures until they have the full approval of both the National Quality Forum (NQF) and Measure Applications Partnership (MAP). These bodies provide critical stakeholder input and are necessary to a sound, transparent measure development process that yields clinically valid and statistically reliable measures. Moving forward without their approval on this or any measure jeopardizes transparency and legitimacy and could lead to inaccurate cost and quality measurement.</p> <p>We that CMS should not increase the weight of the Cost Category or add any additional measures without addressing the concerns raised in this letter related proper risk adjustment, patient attribution, and reliability and accuracy. While we appreciate CMS' point that they are required under current statute to increase the weight of the Cost Category to 30% by performance year 2022, CMS should not sacrifice accurate cost measurement for the sake of meeting a timeline that is years off and could change. Congress could revise the timeline to afford CMS additional flexibility just as it did with the Bipartisan Budget Act. ACP shares the Agency's goal to reward clinicians who are delivering high-quality, efficient care, but reminds CMS that this only works with accurate cost and quality measurement. Otherwise, a host of unintended consequences could ensue, such as clinicians being penalized for treating sicker or older patients. The Agency should instead focus on updating these measures with all due speed and only after they are confident in the methodology and reliability for every cost measure should they look to increase the weight of the Cost Category.</p> <p><u>Conclusion</u></p> <p>It is our hope that based on the concerns raised in this letter, CMS will continue to study, test, and refine the HWR measure until it is proven to be evidence-based, reliable, and valid before it is used to impact physician payments. Above all else, CMS should carefully consider the negative implications that unreliable scores and feedback could have on patient outcomes and access to care. We appreciate the opportunity to offer feedback and your consideration of these comments. The College looks forward to continuing to support CMS in its work to continuously improve and refine the accuracy of cost and quality measurement to ensure physicians are being appropriately evaluated and held accountable for their performance so patients can continue to receive the highest quality care. Please contact Suzanne Joy at 202.261.4553 or sjoy@acponline.org if you have any questions or need additional information.</p>	<p>Jacqueline W. Fincher, MD, MACP</p> <p>Chair, Medical Practice and Quality Committee</p> <p>American College of Physicians</p>	Professional Association	Thank you for your comments. Please see Section 3, Summary of Comments on the MIPS Hospital-Wide All-Cause Unplanned Readmission Measure

Table 4: Verbatim Comments: Out of Scope

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	Type of Organization	Response
12/13/2018	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	My question is about VA patients and how they are attributed to primary care. As an example, if I have a VA patient who elects to go to a primary care individual and then gets transferred to another facility for inpatient care, is that person a VA patient or is that person attributed to the primary care provider?	Roger Wells, PA-C Howard County Medical Center	Individual	Thank you for your question. This is beyond the scope of the current project; however, your question will be shared with CMS.
12/23/18	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	Thank you for the consideration of public comments to the project for development of inpatient outcome measures, MIPS and re-admissions. The report on the "Clinician and Clinician Group Hospital-wide All-cause Unplanned Readmission Measure" is impressive and really well done. My only suggestion for the future is two-fold: 1) The report points to evidence on readmission measures and quality. There continues to be debate and discussion over best measurement and use of readmission data. Additionally, as years go by, more and more data on readmissions and quality can be analyzed. It is my suggestion that readmission research, literature and variances in methodology be analyzed in meta-analysis, and that this meta-analysis be prepared for expert as well as public interpretation. In essence, ongoing, continuous literature synthesis should be encouraged and specifically referenced when future reports point to evidence for readmission measures/methodology in quality. 2) While global systems may differ in delivery and economics, global movement toward health quality as become a shared vision. As such, consideration of data and comparisons should be anticipated and realized for global analytics and global improvements. This may not be a priority for current comments, yet any designs for national scale should consider eventual international cross comparison agenda. Thank you for your time.	Julie Babyar, RN MPH	Individual	Thank you for your comment. This is beyond the scope of the current project; however, your comment will be shared with CMS.
1/4/2019	MIPS Hospital-Wide All-Cause Unplanned Readmission Measure	I feel outpatient services need to be utilized such as labs for anticoagulation upon being on long term coumadin therapy. Utilizing outpatient mental health services for PTSD.	Alice Pushee	Individual	Thank you for your question. This is beyond the scope of the current project; however, your question will be shared with CMS.