Summarized Recommendations for Proposed 2020 Quality Changes

Do not increase the data completeness requirement from 60% to 70%, which would increase reporting burden on clinicians with no clear benefit to patient care at a time of great volatility with the impending MIPS Value Pathway changes. This change would disproportionately impact small practices and would make practices less able to overcome temporary reporting glitches, often caused by the vendor, which could result in more practices seeking hardship requests.

Finalize a delay of the All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions measure until 2021 to allow for stakeholder input and use this time to address past concerns raised by ACP. ACP commends CMS for responding to past requests to solicit stakeholder input and approval by an independent third party, which helps to promote transparency, accountability and program integrity while improving performance measurement accuracy. We urge CMS to address our previously expressed concerns, including low reliability standards, inadequate risk adjustment, flawed attribution, and a lack of actionablity.

Remove unreliable, invalid measures but ensure there are a sufficient number of measures to report, particularly for certain specialties. ACP strongly believes all MIPS performance measures should be evidence-based, actionable, statistically valid, and approved by an independent third party. We support the removal of measures that do not meet this criteria to ensure accurate performance measurement. However, CMS should consider the impact removing a measure would have on a particular specialty or patient population, even if the measure is not commonly reported. If there is a lack of valid, reliable measures for a particular condition or specialty, CMS should work with measure developers to develop or adjust MIPS performance measures, and adopt policies that encourage the development of new measures.

Rather than abandon seldom reported measures, work with developers to improve and promote measures and adopt policies that encourage reporting of new measures. CMS' current policy for scoring new measures actively discourages reporting because practices may not receive more than 3 points regardless of how well they perform. ACP supports transparent, prospective benchmarks because these give practices a predictable target. CMS should consider adopting temporary, prospective benchmarks for new measures and enact policies that encourage reporting of new measures, such as awarding improvement activity credit.

Do not reject measures if the developer does not sign a licensing agreement with CMS. Doing so will discourage development of new measures and could lead to oversight inconsistencies. CMS should facilitate multi-stakeholder collaborations to develop future measures instead.

Instead of requiring all measures to be fully tested prior to nomination, which may slow the development of new QCDR measures, adopt new measures on a trial basis. This would facilitate and expedite the testing of new measures on a large scale without negatively impacting clinicians' performance if refinements need to be made to improve accuracy.

If you have any questions or would like further elaboration on any of these points or other QPP-related topics, please contact Suzanne Joy at sjoy@acponline.org or 202.261.4553 (direct).

Summarized Recommendations for Proposed 2020 Cost Changes

Raise case minimums and increase the minimum reliability threshold to at least 0.75.
Evaluating clinicians on unreliable measures is dangerous and could penalize practices with
already limited resources caring for at-risk patient populations.

Improve risk adjustment and patient attribution methodologies. HCC coding fails to
adequately capture social and other important risk factors that have been proven to have a
strong effect on patient outcomes. ACP supports using more recent diagnostic data to calculate
risk scores on a rolling basis and the development of patient relationship codes. We urge CMS
to develop and implement these with all due expediency, while soliciting stakeholder input.

**Eliminate the Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Cost (TPCC)
measures, which inappropriately attribute broad-based downstream costs to clinicians and
practices.** Use the MVP to facilitate a transition to condition- or specialty-specific measures
which are a more focused, effective form of measuring the costs clinicians are able to influence.

If CMS does move forward with these measures…

Do not double count costs by attributing the same costs to multiple TINs. Divide costs instead.

Require a minimum of four services to establish a pattern of care for the TPCC measure. Two
services do not demonstrate an ongoing physician-patient relationship and would capture a
large amount of one off services with follow-up appointments. Requiring an additional
examination or test will only proliferate additional services or tests when they would otherwise
not be performed, which runs counter to the goal of driving efficient delivery of care.

Institute a case minimum of 35 for both the TPCC and MSPB measures to improve reliability
and promote consistency within the Cost Category.

Finalize proposals to exclude certain specialties and services, including services that occur
prior to the triggering primary care visit, those unlikely to be influenced by a clinician's care
decision (for the MSPB measure), and specialties who infrequently perform primary care
services (for the TPCC measure),. These exclusions will help to improve the accuracy of cost
measurement by excluding services that are outside the clinician's control.

Add additional service-level exclusions to account for non-physician clinicians who could
trigger attribution to a physician practice despite operating in a specialty capacity.

**Finalize a one-year risk window for the TPCC measure but abandon the proposal to divide
into four-week blocks,** which only adds unnecessary complexity and serves little practical
purpose. Instead, divide associated costs between the relevant performance years using
December 31 as a cutoff date.

Summarized Recommendations for Proposed 2020 MIPS Value Pathway

ACP appreciates CMS responding to longstanding calls to reduce burden in MIPS by creating more alignment across the categories and reducing the number of required metrics while providing more regular, actionable performance feedback to support the transition to APMs.

CMS must offer additional opportunities to comment on these proposals and the detailed MVP design, scoring, and implementation methodologies once more fully developed.

Do not mandate the MVP, especially in 2021. Keep the MVP optional. At a minimum, create a multiyear pilot and offer MIPS credit equivalent to the performance threshold for testing MVPs.

Maintain key design flexibilities that will reduce burden, help smooth the transition, and ensure practices can find MVPs that are relevant to their practice and patients, including allowing multiple collection types, ensuring that practices and clinicians can self-select MVPs, offering some choice among a small set of related measures, and allowing sub-TIN reporting.

Structure initial MVP options around the existing specialty measure sets while establishing a process to seek out new MVPs. This will facilitate an easier, faster transition to the MVP while allowing for a continuously expanding pool of MVPs, including specialty-specific MVPs.

Administrative claims based measures can reduce reporting burden but must be applicable to a well-defined set of services that are within the clinician's ability to influence, such as a cost measure tied to a set of services related to treating a particular condition. Stakeholders should be able to comment on CMS claims-based measures and submit their own.

Assign patients voluntarily and prospectively, ideally via patient relationship codes. Knowing which patients they are responsible for empowers clinicians to influence outcomes.

Transform the Promoting Interoperability Category into attestation-based menu measures that align with the other categories; support emerging EHR capabilities; and encourage transferring relevant, actionable data at the point of care. Clinicians should get credit for levering CEHRT to report quality and cost data or perform improvement activities.

Assign point values based on the measure's weight relative to the total MIPS composite score and award points for the same measure toward multiple performance categories.

Provide detailed performance data on at least a quarterly basis, or more ideally in real time, to improve performance and help practices feel prepared to transition to APMs.

Find ways to better and more comprehensively support small practices within the MVP, such as establishing separate measure benchmarks or MIPS performance thresholds.

If you have any questions or would like further elaboration on any of these points or other QPP-related topics, please contact Suzanne Joy at sjoy@acponline.org or 202.261.4553 (direct).