The American Medical Association (AMA) appreciates the opportunity to comment on the Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure for use in the Merit-based Incentive Payment System (MIPS). The AMA strongly believes that it is useful to understand the rate of admissions for patients with multiple chronic conditions particularly for quality improvement. However, measures used in accountability programs must be (1) based on strong evidence, (2) actionable to ensure that improvements can be driven by those held accountable, and (3) proven to be reliable and valid at all levels to which the measure is attributed. Based on the information released for public comment, we believe that additional work is required to meet these minimum criteria and this measure is not ready for implementation in MIPS at this time.

Evidence to support the measure at the clinician and group levels

The AMA believes that attribution must be determined based on evidence that the accountable unit is actually able to meaningfully influence the outcome, which aligns with the most recent National Quality Forum (NQF) report, Improving Attribution Models.[1] This principle is also aligned with the evidence requirements for outcome measures in the NQF Measure Evaluation Criteria, which requires that there be at least one structure or process where the clinician can influence the outcome and this relationship must be demonstrated through empirical evidence.[2] CMS must begin to demonstrate these relationships for an accountable unit prior to implementing this measure in MIPS and we do not believe that CMS has adequately demonstrated this link.

While the AMA agrees that evidence exists to demonstrate that improved care coordination and programs focused on care management can lead to reductions in hospital admissions, the majority of the cited evidence involved multiple partners such as a health system and/or hospital. We also note that not all of the studies demonstrated a decrease in hospitalizations.

We do not believe that sufficient evidence was provided to support that physicians or practices in the absence of some coordinated program or payment offset (e.g., care management fee) can implement structures or processes that can lead to improved outcomes for these patients. Since the care coordination programs and initiatives are mostly led by health plans, integrated delivery systems, accountable care organizations, or other broader entities, assignment of responsibility for the reduction of admissions to individual physicians and practices in MIPS is inappropriate. As CMS continues to expand the types of measures for possible use in MIPS, CMS must establish the underlying evidence used as the basis to attribute a clinical outcome to a specific

[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.
[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.

measured entity such as physician. Therefore, we do not believe that CMS provided sufficient information to support the attribution of this measure to physicians or practices.

Actionability of the measure

The AMA appreciates the thorough evaluation of the various attribution approaches considered and additional clarification on TIN level attribution. While we believe that the options selected are the most reasonable, we are concerned that a clinician's or group's ability to drive improvements on this measure is limited because the developer is using retrospective attribution. The AMA understand that it remains difficult to implement measures that use prospective attribution. However, CMS must begin to explore approaches that more clearly assign patients to physicians and practices in advance of the reporting year to better enable them to drive improvements. The current approach toward attribution along with the use of administrative data that is not timely makes it difficult for physicians to drive toward reductions in admissions.

In addition, the lack of alignment of the various attribution models used for the MIPS outcome and cost measures such as this measure, the Hospital-wide Readmissions (HWR) measure and Total Per Capita Cost (TPCC) measure must be addressed. Based on the proposed changes to attribution in many of these measures to hold more than one physician accountable and/or leverage different approaches (e.g., plurality of charges vs. plurality of visits), physicians and practices will have different patients assigned to them for different measures. This lack of consistency across measures will further decrease a physician's ability to drive improvements in care as they will not be working with a pre-determined set of patients. Rather, patients will be assigned retrospectively and could be assigned to more than one clinician. This scattershot approach within one program is not sustainable and must be addressed to create a system that promotes and facilitates improvements to patients in a way that is also meaningful and actionable by physicians. Therefore, the AMA is extremely concerned that the multiple attribution approaches across measures defeats this purpose and it must be addressed immediately by CMS. Otherwise, this approach will only further increase physician frustration about MIPS and unnecessarilyy increase administration burden.

Rigor of scientific acceptability testing and results

The AMA supports and is encouraged to see that social risk factors were tested and will be included in the risk adjustment approach. **We strongly recommend that dual eligibility be included in the adjustment since the adjustment of a factor should not be dependent on whether it is also adjusted in the overall score within a program as each serves a different purpose.** Bonus points, such as what occurs in MIPS are not always permanent and often minimal to offset the handicap a physician may have compared to their peers who do not treat a large portion of patients with social risk factors. It is also unknown if the additional points added to a physician or practices overall score are enough for compensating physicians who treat patients with social and economic issues. Furthermore, given that the testing demonstrated that dual eligibility

was strongly predictive of an admission, we believe that this variable should be included in the final model.

We also remain concerned that CMS continues to test social risk factors after assessment of clinical and demographic risk factors and it is unclear why this multi-step approach is preferable. On review of the Evaluation of the NQF Trial period for Risk Adjustment for Social Risk Factors report,[3] it is clear that the approaches to testing these data should be revised to strategies such as multi-level models or testing of social factors prior to clinical factors and that as access to new data becomes available, it may elucidate more differences that are unrelated to factors within a hospital's or physician's control. Additional testing that evaluates clinical and social risk factors at the same time or prior to clinical variables rather than the current approach with clinical factors prioritized should be completed. This additional testing may provide support for inclusion of additional variables such as primary care physician density and further emphasize the need to include dual eligibility.

The AMA also encourages CMS to continue to ensure that measures meet minimum acceptable thresholds for testing such as 0.7 for reliability and demonstrate the validity when attributed to the physician or practice. Both reliability and validity must be demonstrated prior to implementation in MIPS.

Specifically, we were only able to identify measure score reliability testing at the TIN level and could not find any information on what the reliability results were for individual clinicians. As a result, it is unclear whether it is CMS' intent to apply the minimum sample size of 27 patients or greater to individual clinicians or whether the measure will only be applied at the TIN level based on the testing provided. If at the TIN level, the level of the group size should be set at a number that meets high reliability (0.7). We request that CMS clarify whether the results provided are inclusive of individuals in addition to groups, including size of the group. If not, CMS needs to provide the results for the NPI/TIN level and clarify what minimum sample size for individual physicians is supported by the reliability testing.

In addition, we recommend that CMS set the reliability target at 0.7 or greater. We acknowledge that this change would require that the minimum sample size be set at equal or greater 62 patients and reduces the number of TINs to which the measure would apply from 45.3 percent to 23.9 percent. However, even with this change, 81.9 percent of patients with multiple chronic conditions would still be included in the measure and further ensure that the results yield more reliable and accurate representations of the quality of care provided.

As noted in the report, CMS must complete further testing to demonstrate the validity of the measures as they relate to each of the accountable units to which each measure is

[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.

attributed. We recommend that CMS consider testing that demonstrates whether this measure attributed to physicians and practices is correlated to other outcome measures, such as hospital-wide readmissions (HWR) or total per capita cost (TPCC). Face validity alone should not be considered sufficient. Information of the results of the face validity testing would have been helpful to review in this report but, if it has not yet been completed, we encourage CMS to consider broadening those surveyed beyond the Technical Expert Panel as they may have an inherent bias given their participation in developing the measure.

In conclusion, CMS must balance the desire to apply this measure to the broadest number of physicians possible with the unintended consequences of inappropriately attributing measures to physicians for which they cannot meaningfully influence patient outcomes. The AMA requests that CMS carefully consider the potential misinformation that could be provided to patients and caregivers if the measures do not have a clear evidence base to support attribution of the outcome to a specific physician and could potentially produce scores that are invalid and unreliable.

The AMA appreciates the opportunity to provide our comments on the draft admission measure for use within MIPS. If you have any questions regarding our comments, please contact Koryn Rubin, Assistant Director, Federal Affairs, at koryn.rubin@ama-assn.org or 202-789-7408.