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October 5, 2020

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1734-P
P.O. Box 8016
Baltimore, Maryland 21244-8016

Re: Response to the Medicare Program CY 2021 Quality Payment Program Proposed Rules

Dear Administrator Verma:

The Physicians Foundation appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) 2021 Quality Payment Program (QPP) Proposed Rule published on August 17, 2020. [The Physicians Foundation](#) is a 501(c)(3) organization with a governing Board of Directors representing 17 state medical societies and three county medical societies across the country.

The Physicians Foundation shares CMS's commitment to make care safer and more affordable and to work with communities to help Americans live healthier lives. The Foundation's mission is to support and empower all physicians to provide high quality care and take a leadership role in shaping the future of health care, via research, education, and innovative grant making.

For over a decade, the Foundation has provided leadership on the [impact of the social determinants of health \(SDOH\)](#) on patients and the physicians caring for them. We have done so recognizing [Americans agree on what they need to be healthy](#): safe homes, healthy food, and a decent job. Likewise, in the Foundation's [2018 survey](#) of more 8,500 physicians, almost 90% said their patients had a serious health problem linked to poverty or other social conditions. The Foundation works closely on these issues with its partners, the Center for the Study of Physician Practice and Leadership at Weill Cornell Medicine and The Health Initiative.

While we commend CMS for proposing measures that consider the impact of COVID-19 on the quality, delivery, and experience of care, we are concerned that some of CMS's proposals do not fully recognize the impact of SDOH on patients or their physicians. The failure to include SDOH in quality measures and payment models is a missed opportunity to identify primary SDOH and it creates unrecognized financial risk to the health care system; penalizes physicians for serving more vulnerable patient populations; and escalates [the risk of physician burnout](#). The Assistant Secretary for Planning and Evaluation's (ASPE) recent [Report to Congress on Social Risk and Medicare's Value-Based Purchasing Programs](#) reflects the growing imperative for HHS to account for social risk in quality measures and payment models.

A recent study found that physicians caring for patients with increased social risk have [worse MIPS scores](#), especially among dual eligibles. Moreover, it is now well-established that patients with increased social risk are associated with significantly [higher annual health care expenditures](#). For example, a food insecure diabetic costs the health care system [\\$4,413 more](#) annually than a diabetic who is not food insecure. In a value-based environment, this represents financial risk to the system and practicing physicians.

Historically, the QPP has not accounted for SDOH in its quality measures, financial incentives, category weights, or performance pathways – despite SDOH being a core strategic plank to achieve the national value-based care [payment goals](#). Through its 2021 rule changes, CMS can align its stated commitment to SDOH with regulatory and policy mechanisms to deliver greater value care at lower costs. This is imperative in COVID-19's wake, as Americans struggle with food insecurity, housing instability, and other SDOH – and the impact of these challenges on health care costs and outcomes grows. We hope that CMS will consider the following recommendations related to specific proposed rule changes for 2021.

MIPS Performance Category

Policy Area: Complex Patient Bonus

Proposed rule change: Under CMS's existing policy, physicians, groups, virtual groups and APM entities can earn up to 5 bonus points to account for the complexity of their patient population. CMS is proposing to double the complex patient bonus for the 2020 performance period only (up to 10 bonus points) to account for the additional complexity of treating patients due to COVID-19.

Recommendation #1: Increased bonus points will be crucial for the 2020 performance period, but this is not sufficient. COVID-19 will have a long economic tail – with protracted joblessness and associated struggles to afford food or rent – resulting in higher rates of diabetes, mental health, substance use, and other chronic conditions. Recognizing that physicians participating in MIPS will face significant negative financial implications as a result, we recommend the following:

- Increase the complex patient bonus to 15 points during the 2020 performance period and maintain it at 10 points during the 2021 performance period and beyond. This approach accounts for the immediate, severe implications of COVID-19 and its long-term economic impact on patients and their physicians. It is also consistent with CMS's proposal to not use historical quality benchmark data because conditions have been fundamentally altered due to COVID.
- Include [ICD-10 Z codes](#) tagged to “persons with potential health hazards related to socioeconomic and psychosocial circumstances” in calculating the complex patient bonus. Currently, the bonus is calculated using the proportion of dually eligible beneficiaries and hierarchical condition category (HCC) score as a crude proxy for social risk. A more accurate means of assessing complexity would be to include these ICD-10 Z codes, such as Z59.0 homelessness, Z56.0 unemployed, or Z59.5 extreme poverty.

Rationale for Recommendation #1:

Even pre-COVID, a key aspect of the transition to quality-based payments was the disproportional effect on physicians serving complex populations, particularly those with high social risk. Effective treatment of complex patients requires physicians to undertake time intensive and costly activities, e.g. coordinating specialists, home health agencies, and social

workers; navigating time-consuming prior authorization processes; and *maintaining* continuity of care with patients who have unstable social circumstances.

[MedPAC's June 2018 report to Congress](#) highlighted the impact of social risk on quality, citing numerous studies finding that hospitals with larger shares of low-income Medicare patients have higher readmission rates because of individual and neighborhood effects. Most recently, a cross-sectional [study of physicians participating in MIPS](#) in 2017 found that those serving the highest proportion of dual eligibles had significantly lower MIPS scores than physicians with lower proportions of these patients.

COVID-19's sustained impact on patients' social risk and the economic implications of that risk for physicians creates an only greater imperative for CMS to enact the recommendations above. In COVID-19's wake, not only will the proportion of dual eligible patients likely increase, but a significantly larger number of patients will present with elevated social risk. It is important that CMS recognizes COVID's long-term effects by elevating and maintaining the complex patient bonus and leveraging its relevant ICD-10 Z codes to ensure greater accuracy in calculating these bonuses. Importantly, these changes would have a significant positive impact on physicians in smaller practices and those in rural communities – at a time when such practices are most needed and most vulnerable.

Policy Area: Quality Measures

Proposed rule change: CMS is proposing 206 quality measures for the 2021 performance period, including changes to 112 existing MIPS quality measures, changes to specialty tests, removal of measures from specific specialty sets and 14 quality measures, and two new administrative claims outcomes.

Recommendation #2: We appreciate the attention to measure development and refinement, yet one of the most significant gaps in the QPP – both MIPS and APMs – is the lack of measures that address SDOH, which significantly impact health care outcomes and cost. Currently, not a single measure in the QPP addresses SDOH. We strongly recommend the following:

- *Introduce the first SDOH performance measure to the 2021 MIPS quality measures*, to enable the collection of critical data to quantify the impact of these measures on cost and quality – and, if appropriate, be incorporated into the MIPS cost and quality benchmarks. Consistent with CMS's commitment to ["Patients over Paperwork,"](#) we recommend that for each SDOH measure added, CMS eliminate 5 other administrative or other measures.
- *In particular, prioritize a 2021 MIPS quality measure tied to screening for food insecurity*, using the CMS food insecurity screening question in the current [Accountable Health Communities Pilot](#) (AHC) that was subject to an expert panel review. In 2021, this should be a pay-for-reporting measure to establish a baseline; going forward, the measure could incentivize reductions in food insecurity through associated quality improvement activities and care coordination. Ultimately, the QPP measurement pipeline could formulate an additional set of SDOH measures (such as housing or transportation) and a subset of physicians participating in MIPS could be asked to collect these additional "test" measures to evaluate their impact on cost and quality outcomes.

Rationale for Recommendation #2:

There are several reasons why CMS should create this first SDOH measure. First, CMS has committed to creating [meaningful measures](#) that reflect the voice of the patient and the realities of practicing physicians. These are linked to quality domains including: (1) promoting effective

prevention & treatment of chronic disease; (2) working with communities to promote best practices of healthy living; and (2) making care affordable. In the Physician Foundation's [2018 survey](#) of more 8,500 physicians, almost 90% said their patients had a serious health problem linked to poverty or other social conditions. Yet, absent a single SDOH measure in the QPP, the impact of food insecurity and other SDOH on patients' outcomes and costs and the economic implications for physician practices and CMS will remain invisible.

Second, it is well-documented that SDOH have a significant negative impact on health outcomes and cost. [Food insecurity](#), for example, is associated with significantly more emergency department visits and hospitalizations and increased odds of being in the top 10% of health care expenditures. Creating a 2021 MIPS food insecurity measure will lay the foundation for CMS to begin to address squarely this underlying driver of utilization and cost.

Third, there is a growing consensus that CMS must act to address SDOH. A 2021 MIPS SDOH measure would enable alignment between MIPS and the national value-based purchasing goals that have SDOH at their [core](#). Further, such a measure builds on the momentum established by the Administration through CMS's recent [MLR final ruling](#) incentivizing payors' investment in social supports for chronically-ill Medicare Advantage members. This approach is also consistent with ASPE's March 2020 [Report to Congress](#) calling on CMS to "explore ways to encourage providers to collect social risk information."

Participation Pathway

Policy Area: MIPS Value Pathways

Proposed rule change: Proposed revision to the MIPS Value Pathway (MVP) Guiding Principles intended to simplify the MIPS program, reduce the burden to every clinician, relate to physician's scope of practice and be more meaningful to patient care and population health.

Recommendation #3: As physicians, we agree with the MVP goal of simplifying MIPS, making it more meaningful for physicians and patients, and ultimately improving the quality of care, reducing health care costs and improving the health of the population. At the same time, we are confident that the MVP will not achieve these intended outcomes if it fails to account for SDOH, especially in the context of COVID-19 and its long-term economic impact on patients and their physicians. We strongly recommend the following:

- *Revise the MVP Guidelines to make explicit CMS's commitment to recognize and address SDOH and their impact on physician practice.* In particular, we recommend the following revisions (in bold) to the draft MVP Guidelines below:
 1. MVPs should consist of limited, connected, complementary sets of measures and activities that are meaningful to clinicians, which will reduce clinician burden, align scoring, **recognize the impact of social risk factors**, and lead to sufficient comparative data.
 2. MVPs should include measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers in evaluating clinician performance and making choices about their care and **their overall health and well-being**; MVPs will enhance this comparative performance data as they allow subgroup reporting that comprehensively reflects the services provided by multispecialty groups.

3. MVPs should include measures selected using the Meaningful Measures approach and, wherever possible, the **community and** patient voice must be included, to encourage performance improvements in high priority areas.

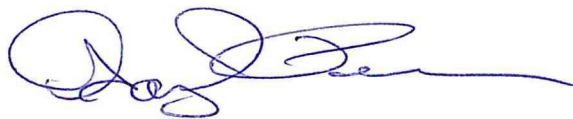
Rationale for Recommendation #3:

Currently, the MVP Guiding Principles are narrowly focused on medical care. Yet, it is well-documented that health-related social needs and associated behaviors drive [over 70% of health outcomes](#). It is imperative that the MVP Guiding Principles explicitly recognize that health care outcomes and cost are shaped by, but go beyond, physicians and the care they provide and are substantially attributable to patients' lived realities and community context – like access to healthy food or safe housing. In the wake of COVID, any viable MVP must go beyond clinical care to include SDOH, if it is to be meaningful to practicing physicians, relevant to population health, and reasonably expected to reduce costs and improve outcomes. Making CMS's commitment to recognizing social risk factors explicit in the revised Guiding Principles above will enable key stakeholders to more fully partner with CMS in the design and implementation of successful MVPs.

Summary

We urge CMS to adopt the recommendations above for the QPP as an extension of its commitment to address the SDOH across a number of regulatory and legislative actions. In doing so, CMS will send a strong signal to the market that the realities of patients' lives and physician practice are core to its mission, especially in the wake of COVID-19. It would also ensure future payment and care delivery models are designed to focus on health, rather than only treating and managing illness. We ask that CMS support us and our physician colleagues across the country with processes and structures that allow us to provide highest quality, comprehensive care to our patients and dedicate ourselves even more fully to serving them, rather than meeting administrative and regulatory requirements. We are grateful for CMS's leadership role in this regard, and we stand ready to work together with the Agency to that end. We would be glad to provide further information about any of the comments above, should the opportunity arise.

Respectfully submitted,



Gary Price, MD, President



Robert Seligson, Chief Executive Officer