AMERICAN OSTEOPATHIC ASSOCIATION

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Elizabeth McGlynn, PhD, MPP and George Isham, MD, MS
Coordinating Committee Co-Chairs
Measures Application Partnership
1030 15th Street, NW
Washington, DC 20005

Dear Drs. McGlynn and Isham:

On behalf of the American Osteopathic Association (AOA) and the close to 130,000 osteopathic physicians and osteopathic medical students we represent, thank you for the opportunity to respond to the Measures Application Partnership's (MAP) *2017 Considerations for Implementing Measures in Federal Programs: MIPS and MSSP*.

The osteopathic profession strongly supported passage of the Medicare Access and CHIP Reauthorization Act (MACRA), and remains optimistic as we move towards a system that aligns well with the osteopathic philosophy of care – treating the whole person with a strong focus on prevention, wellness, and quality. During the law's development, the AOA was especially supportive of MACRA's focus on the value of care provided over volume. As defined in MACRA statute, the Merit-based Incentive Payment Systems (MIPS) creates a new framework for assigning value to care. The MAP is strongly positioned to favorably shape the implementation of the MIPS program and we are pleased to provide the following comments to the MAP as it undertakes this effort:

1. **We support MAP's efforts to include high-value measures.**

The osteopathic approach to medicine supports high-quality care in which patient-centeredness and coordination across members of the care team are hallmarks. These fundamental aspects of high quality care should be recognized through appropriate care measures. As such, we support the inclusion of "high-value" measures, including team-based care measures and patient-centered care measures, that reflect this model of care. Regarding outcome measures, we support the development of these metrics with caution that they appropriately include work performed by the care team. Further, we offer that both risk adjustment and socio-economic factors should be considered in the development of outcomes measures. This approach will incentivize the continuation of care to high-risk and high-need patients for whom care teams must contribute significantly more resources to achieve favorable outcomes. In addition, we caution that patient-reported measures must reflect the patient's clinical experience and not be inclusive of non-clinical factors over which the care team does not have control. Physicians should be measured against metrics which they can reasonably control.

Regarding appropriate use measures, we applaud the intent to base clinical care on evidence. AOA has long been a supporter of the Choosing Wisely campaign, but we caution that a cookie-cutter approach to medicine would be a disservice to patients. As such, appropriate use measures should be developed only when there is an abundance of established evidence in both the literature and in clinical practice, and should incorporate flexibility for physicians to weigh the patient's unique circumstances.

2. **We support MAP's work to pursue appropriate attribution within measures.**

As attribution will be increasingly used in federal programs, in particular MIPS' resource use performance category, we urge all stakeholders to pursue measures that can be appropriately attributed to members of the care team. We acknowledge that the coordinated, team-based model of care which yields high-quality care also complicates attribution. However, we strongly feel that proven models of care should not be minimized in order to simplify attribution methods. We recognize that these attribution challenges also include the timeliness of attribution and that the metric attributed to the physician should relate to an outcome that the physician could reasonably influence. We therefore offer that MAP may be positioned to develop parameters for attribution though a collaborative process, and that all measures should be measured against these criteria during the consideration process.

3. **We oppose MAP's efforts to remove topped out measures.**

We oppose the removal of topped out measures as defined by measures on which eligible clinicians perform well with little room for improvement. High performance on a particular measure, if aligned appropriately with the goal of improving quality, should be rewarded and more importantly should be incentivized to maintain – this, after all, is the essence of improving patient care. While we understand that MAP seeks to incentivize continued growth, the continued increase of performance measures and thresholds, while tied to payment under MIPS and MSSP, creates an exhausting system in which eligible clinicians have little opportunity to consider innovative practices because they are instead continually meeting rising prescriptive thresholds. This system can be a disadvantage for both patients and the health care system which can benefit from the innovative solutions developed by physicians when provided with the opportunity and resources to make such changes. We urge MAP to leave room for innovation and organic growth, rather than developing increasing prescriptive measures.

4. **We support a collaborative, transparent, and timely process for measure development and evaluation that will maximize efficiencies and shared knowledge across stakeholders.**

Though current measures are numerous, disparate measure development has resulted in redundancies that should be streamlined. Collaborative measure development that includes relevant stakeholders will enable future measures to be better aligned with existing measure gaps, and without duplication of efforts or products. As such, it is vital that measure development and evaluation be a transparent process to which relevant stakeholders are invited.

Please do not hesitate to call on the AOA for insight as you complete this report. To do so, or for additional information, please contact Laura Wooster, Interim Senior Vice President for Public Policy, at lwooster@osteopathic.org, or (202) 349-8747.

Sincerely,

Boyd R. Buser, DO
President