AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G 200
Independence Avenue, SW
Washington, DC 20201

Re: 2025 Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) Candidate Feedback

Dear Administrator Brooks-LaSure:

On behalf of our physician and medical student members, the American Medical Association (AMA) appreciates the opportunity to comment on the 2025 Merit-based Incentive Payment System (MIPS) Value Pathway (MVP) Candidates prior to their inclusion in future proposed rulemaking. **As we navigate the complexities of these proposed changes, the AMA strongly urges CMS to consider the following key recommendations for enhancing the MVPs:**

- **Ensure the MVPs are revised to be more meaningful and directly beneficial to both physicians and their patients, reflecting the real-world clinical scenarios and challenges faced in practice;**
- **Remedy flaws in the cost measures that are included in the 2025 MVP Candidates;**
- **Use the MVP framework as a testing ground for new scoring policies that effectively address existing shortcomings in both quality and cost measures, especially for subspecialists, including "topped out" measures and cost measures with little variation; and**
- **Adapt population health measures specifically for each MVP Candidate, ensuring they are relevant and contribute to meaningful improvements in patient care outcomes.**

Please find below our detailed recommendations and specific comments regarding the proposed 2025 MVP Candidates.

1. **CMS should propose revised MVPs that are meaningful to physicians and their patients rather than moving forward with the 2025 MVP Candidates as written.**

The Achilles heel in each of the 2025 MVP Candidates, as well as the vast majority of the MVPs developed to date, is CMS' proposition that specialists who provide different services to different patients with different conditions or clinical episodes should be held accountable against one another. This diverges from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) statute's emphasis on episode-based cost measures and patient condition codes, as well as the premise of bundled payment models being tested by the CMS Innovation Center and other payers, which examine condition-specific or acute inpatient/outpatient episodes that typically last up to 90 days. CMS believes that MVPs should offer

participants a window into their potential performance in Advanced Payment Models (APMs). To achieve this aim, we urge CMS to better align MVPs and bundled payment APMs by focusing on conditions and episodes of care, rather than specialties.

Furthermore, the 2025 MVP Candidates are counter to physicians' practice and person-centered care as they do not link quality and cost for the same patient or the same type of care. **The AMA and organized medicine have previously written to CMS about our opposition to organizing MVPs at the broad specialty level, and the AMA continues to urge CMS to propose MVPs that are more clinically relevant by focusing on a discrete condition or clinical episode, even if they are only provided by a subset of the specialty's members or by a particular subspecialty.**

For example, it is misleading for patients and physician practices to suggest the Gastroenterology (GI) Care MVP Candidate reflects a comprehensive measurement and evaluation of "GI Care" with only a label while omitting the full spectrum of care under the purview of gastroenterologists. With six quality measures assessing screening colonoscopy, two quality measures assessing Hepatitis C, one quality measure assessing Inflammatory Bowel Disease , and one episode-based cost measure focused on screening/surveillance colonoscopy, the measure set has limited, specialty-specific measures, which could disadvantage the many providers who subspecialize in conditions such as: motility and functional GI disease, Inflammatory Bowel Disease (a term for two distinctly different conditions: Crohn's disease and ulcerative colitis), interventional/advanced endoscopy, nutrition/obesity, and hepatology/transplant hepatology.

Instead, the AMA echoes the recommendation of the American College of Gastroenterology (ACG), American Gastroenterological Association (AGA), American Society for Gastrointestinal Endoscopy (ASGE), and GI Quality Improvement Consortium (GIQuIC) that this MVP should have a narrower focus on colorectal cancer prevention since the proposed MVP does not account for the full spectrum of GI care. A singular clinical condition will offer the granularity needed to be meaningful to both patients and clinicians and enhance comparative reporting and quality improvement. A GI Care MVP initially centered on colorectal cancer prevention is an opportunity to present a clinically coherent MVP for a subset of GI Care providers that can be grown as new reliable quality and episode-based cost measures are added to the Quality Payment Program (QPP). There is also a growing body evidence that colorectal cancer rates are increasing in younger patients so this would be an opportunity to highlight the importance of tackling this disease, consistent with the White House Cancer Moonshot.

As a second example, we share the concerns of the American Academy of Dermatology Association (AADA) that the Dermatological Care MVP Candidate uses an excessively broad measure set that lacks alignment and is incapable of offering meaningful feedback to enhance patient care as it encompasses both inflammatory and neoplastic disease processes. These distinct disease processes are treated by different subspecialties of dermatology and the overly broad measure set in the candidate MVP will lead to unfair comparisons among dermatologists with varying sub-specializations and patient populations. Dermatologists who treat psoriasis (currently accounted for in the quality measures) do not treat melanoma (currently the only cost measure). If CMS decides to move forward with combining a cost measure of an oncologic disease with quality measures related to inflammatory disease, it uncouples the important nexus of cost and quality to determine value for patient care. Failing to address these distinctions could lead to misleading comparisons that do not reflect the nuances of each subspecialty's practice, potentially compromising the quality of care for patients. **The AMA joins the AADA and recommends narrowing the scope of this MVP to focus on skin cancer, a neoplastic disease, which has a cost measure and clinically relevant quality measures, allowing for meaningful measurement.**

As a third example, the Surgical Care MVP Candidate attempts to lump numerous, unrelated surgical specialties (e.g., general surgery, neurosurgery, cardiac surgery, breast surgery) into a single MVP. This is not only inappropriate from a clinical perspective, but it provides little added value—beyond the current MIPS specialty quality measure sets—in terms of assisting surgical specialists with identifying the most relevant MIPS measures. According to CMS' MVP guiding principles, "MVPs should consist of limited, connected, complementary sets of measures and activities that are meaningful to clinicians, which will reduce clinician burden, align scoring, and lead to sufficient comparative data." This MVP, as currently constructed, will not satisfy any of those goals. Instead, it will create confusion and discourage movement into MVPs among surgeons, who might assume that CMS plans to evaluate their performance against other unrelated surgical specialties, pitting one specialty against another.

We understand that CMS believes developing condition-focused or clinical episode focused MVPs would result in a thousand MVPs blooming, so to speak. We disagree and firmly believe that the agency has numerous options at its disposal to prevent such an outcome. **First, the AMA reiterates its recommendation that CMS develop a prioritization framework for MVP development in collaboration with the national medical specialty societies.** The agency could focus development on the Administration's priorities and could solicit input from interested parties about opportunities to improve care delivery, patient outcomes, and reduce avoidable costs. MVPs could then be developed in those high-priority clinical areas.

For example, CMS previously established the Improving Care for Lower Extremity Joint Repair MVP, which includes quality and cost measures that evaluate care for patients needing lower extremity surgical repair, such as fractures and total joint replacements. Unlike a broad MVP that would include orthopedic surgeries from multiple, significantly different anatomic regions, this MVP has the potential to provide physicians with actionable performance feedback about patient outcomes and avoidable costs, as well as useful information to patients who may be able to shop around for this surgery. With this MVP as a precedent, **CMS should work with national medical specialty societies to develop MVPs around targeted episodes of care or conditions and with appropriate measures moving us closer towards patient-centered care.**

Alternatively, CMS could develop MVPs around the episode-based cost measures, such as by adopting the Cataract Surgery MVP put forward by the American Academy of Ophthalmology, the American Society of Cataract and Refractive Surgery, and the American Society of Retina Specialists. This would give CMS a means of limiting the number of MVPs, and MVPs developed under this approach could grow over time as new episode-based cost measures are added. **The AMA and national medical specialty societies stand ready to work with CMS to develop MVPs that are more clinically relevant to physicians and their patients.**

2. **CMS should remedy the problems with the cost measures included in the 2025 MVP Candidates prior to or in the same rulemaking as the proposed MVPs.**

Since CMS made the most recent cost performance category information available to physicians in August 2023, the AMA has heard a growing chorus of concerns about the cost measures. These problems were outlined in detail in an October 27 letter and a December 18 letter to the agency. Most relevant to the 2025 MVP Candidates are the problems with the Cataract Removal with Intraocular Lens (IOL) Implantation, Melanoma Resection, and Total Per Capita Cost (TPCC) measures.

First, the AMA has raised its concerns that the cataract surgery cost measure benchmark is based on incomplete data. We heard that a cataract surgeon scored in the 10th decile for the cataract surgery

measure and, upon further investigation, realized that their patient level data file shows missing operating room fees. Clearly, there should be operating room charges because the measure captures surgeries done in the hospital outpatient department or ambulatory surgery center. Ophthalmologists cannot and should not be held accountable for the facility's billing practices. If the facility chooses not to bill their claim in a timely manner or has claim errors, it should not be reflected in the ophthalmologist's cost score. If episodes with clearly incomplete billing are being factored into the average cost per episode, then the benchmarks and deciles are wrong. Incorrect benchmarks and deciles hurt the physicians with accurate and complete billing because those physicians appear to be more costly and get pushed to lower deciles. **CMS should conduct a study to examine the extent of the problem for this specific measure and seek input from the relevant national medical specialty societies on a policy to exclude from benchmarks any episodes that are missing critical elements, such as operating room charges.**

Second, the AMA remains concerned that the melanoma resection measure is making apples-to-oranges comparisons. We learned that dermatologists who are receiving referrals appear to be higher spenders due to a difference in diagnosis coding for the pre-operative services. Dermatologists who see a patient with a suspicious mark will conduct a pre-op visit and biopsy while coding as Neoplasm of Unspecified Behavior (NUB) as it is not yet known whether the lesion is melanoma or not. Because these services are billed with the NUB diagnosis code, they are not included in the cost measure. However, once the lesion has been confirmed as melanoma and referred to a specialist, the specialist then uses a melanoma-specific diagnosis code for the pre-op visit and any related testing, such as bloodwork. Thus, the specialist who receives referrals following a melanoma diagnosis artificially appears to have higher spend due solely to differences in diagnosis coding. **CMS should seek input from the relevant national medical specialty societies on creating additional subgroups within this measure based on whether the attributed physician is the physician making the diagnosis or providing care based on a referral.**

Third, we continue to strongly believe that physicians should not be measured on the TPCC measure as it holds them accountable for all Medicare Parts A and B spending, the vast majority of which they cannot influence and are likely not even aware of, particularly as CMS still does not provide physicians with information on claims submitted by other physicians and facilities from which their patients receive services. Furthermore, we are concerned that including TPCC in MVPs designed to promote investments in preventive services, such as the Gastroenterology Care MVP, may unfairly penalize physicians for successfully improving the utilization of recommended preventive services as total costs are measured in the same year as those services are provided. While higher utilization of preventive services may reduce costs in the long term, neither the Gastroenterology Care MVP nor TPCC are designed to capture those services and therefore does not account for the value of preventive services. CMS is essentially penalizing physicians for keeping their patients healthy. **Therefore, we strongly oppose inclusion of the TPCC overall, but particularly in MVPs with preventive care measures such as the Gastroenterology Care MVP, which also includes a relevant episode-based cost measure.**

Given the combined magnitude of these concerns with the Cost Category, we reiterate our recommendation to reweight the 2022 cost performance category to nullify the negative financial impact of these flawed measures on physician practices who are already having to absorb a 3.4 percent reduction to the Medicare conversion factor that went into effect on January 1. CMS should then update the MIPS payment adjustments accordingly and reprocess any claims already paid at the incorrect payment adjustments. Looking ahead, **we strongly urge CMS to fix these problems in subregulatory guidance, like the change that CMS made to the attribution methodology for the chronic condition episode-based cost measures, which should result in fewer misattributed episodes, or in the 2025 proposed QPP rule.** All changes should be retroactively applied to the 2023 and 2024 performance periods prior to the corresponding payment adjustments taking effect in 2025 and 2026, respectively.

Finally, we strongly urge CMS to release the 2022 Experience Report and Public Use Files with information about the cost measures as soon as possible and, at a minimum, prior to the public comment period on the proposed 2025 MVP Candidates. The most recent data available on the cost measures dates back to the 2019 performance period, prior to introduction of most of the episode-based cost measures and the revised TPCC and Medicare Spending Per Beneficiary clinician measures. It is not possible to provide substantial, constructive input about draft MVPs and in particular the inclusion of new episode-based cost measures without data on how the measures are functioning.

3. **CMS should use MVPs as an opportunity to test new alternative scoring methodologies that address existing problems with quality and cost measures, including "topped out" quality measures and cost measures with little variation.**

For instance, regarding cost measures with little variation among the ten deciles, we have previously expressed concern with the Screening/Surveillance Colonoscopy measure because the variation in cost is extremely limited among the ten deciles. The difference between a score in the tenth versus the fifth decile is less than $200. **For the cost measures, we recommend that CMS consider establishing a range of reasonable costs for physicians who provide high-quality care.**

As CMS has acknowledged, some MVPs feature "topped out" quality measures which are limited to a maximum of seven points. Some subspecialties in particular have a limited selection of quality measures to choose from and may have no choice but to select topped out measures, inherently limiting their chances at a high-quality score compared to their peers. This effect is compounded when the same subspecialists do not have a relevant cost measure to report as part of the MVP, and therefore have their cost category reweighted to quality. Physicians are very concerned about having a diversity of physicians in the same broad specialty MVP, wherein some subspecialists who provide the service for which there is an episode cost measure are scored on it and others have no weight for cost at all. Although CMS will not compare performance among MVP participants, there could be a perception that these comparisons will take place, which would lower interest in participating in an MVP. Further, this would not provide meaningful feedback among subspecialists in the MVP. Therefore, we implore CMS to revisit capping the scores of topped out quality measures when there are no alternative measures to report. As the AMA has previously recommended, this would also be a good opportunity to encourage the testing of new measures by awarding physicians full credit for reporting of a new measure for the first two reporting periods, which will promote the development of new quality and cost measures, which will in turn promote the growth MVPs.

These innovative solutions to current scoring issues would advance the goal of MVPs to improve the accuracy and clinical relevancy of cost and quality evaluations.

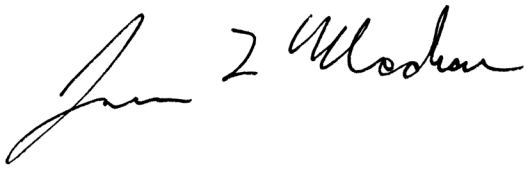
4. **CMS should remove the population health measures requirement for MVPs.**

While measuring improvement on population health is important, introducing additional, one-size-fits-all requirements rather than considering the measures for potential use into existing criteria and tailoring them to each MVP adds unnecessary complexity and is less effective at improving patient outcomes. For example, the population health measures are focused on hospital care that is not clinically relevant to ophthalmologists. While ophthalmologists and other specialists including primary care may be exempt from some of the measures, inclusion of these measures as a foundational layer would result in confusion and concern about the applicability of those measures and MVP. It also adds an additional category into the program with burdensome and uneven scoring rules that was never intended or required by Congress in the MACRA statue. Maintaining the foundational requirement just adds additional quality measure

requirements and standards into the program and increases administrative burden. Because CMS has added this new foundational category, we believe it is not accurate to say that MVPs reduce the number of quality measures that a physician or group must report. In addition, given the measures are based solely on administrative claims, CMS is potentially introducing the same flaws we have repeatedly highlighted with the global cost measures into this new category. **Therefore, we urge CMS to remove the flawed population health measures and category as a foundational requirement as it fails to accurately capture quality.**

Thank you for considering our recommendations to improve the 2025 MVP Candidates. Please do not hesitate to contact Margaret Garikes, Vice President of Federal Affairs with any questions or to discuss further at margaret.garikes@ama-assn.org.

Sincerely,



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