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October 18, 2023

Michael E. Chernew, PhD
Chair
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, DC 20001

Re: AMA Comments on October 2023 Meeting–Medicare's Payment Rates for Clinicians

Dear Dr. Chernew:

On behalf of the physician and medical student members of the American Medical Association (AMA), I write to provide input to the Medicare Payment Advisory Commission (MedPAC) in its deliberations about Medicare's payment rates for physicians and other clinicians. During the October 2023 meeting, MedPAC discussed a range of topics that impact Medicare physician payment, including the lack of an inflation-based update, problems with the Merit-based Incentive Payment System (MIPS), and incentives for participating in advanced alternative payment models (APMs).

The AMA is pleased that MedPAC is discussing overdue reforms to the Medicare physician payment system. Along with state medical and national specialty societies, the AMA is advocating for long-term solutions to the unsustainable Medicare physician payment system to better meet the needs of physicians and patients. We have developed a set of principles to guide our efforts and, overall, believe that a rationale Medicare payment system would ensure financial stability and predictability, promote value-based care, and safeguard access to high-quality care. We also appreciate the recent opportunity to meet with commission staff to discuss these issues in detail.

We appreciate your thoughtful discussions on Medicare physician payment reform at the October meeting. In our comments, the AMA:

- Strongly agrees that an inflation-based update to Medicare physician payment is necessary to keep pace with the increased costs of practicing medicine;
- Highlights the large and frequent redistributions caused by budget neutrality within the Medicare physician payment schedule;
- Shares pertinent data about the drivers of volume and intensity growth within the Medicare physician payment schedule;
- Underscores the extensive work of the AMA/Specialty Society Relative Value Scale Update Committee (RUC) to identify and revalue potentially misvalued services;
- Agrees that MIPS is meritless and recommends statutory changes to reduce burden, increase clinical relevance, and prepare physicians to move to APMs; and
- Discusses our support for the Value in Health Care Act, which would continue the advanced APM incentive payments, among other important changes to increase physician participation in APMs.

1. Need for an Inflation-Based Update to Medicare Physician Payment

During the October meeting, the Commission expressed near universal support for updating Medicare physician payment by an inflation-based measure, such as the Medicare Economic Index (MEI). **The AMA strongly agrees and urges MedPAC to recommend that Congress update Medicare physician payment by 100 percent of MEI in 2025.** Such an update would allow physicians to invest in their practices and implement new strategies to provide high-value, patient-centered care.

The AMA applauded MedPAC's recommendation earlier this year that Congress increase the 2024 Medicare physician payment rate above current law with an inflation-based update tied to the MEI. While we commended the Commission for taking this significant step, we noted that implementing inflation-based update based on only half of the full MEI growth rate would be a missed opportunity to meaningfully address the perennial issue of Medicare physician underpayment that threatens stable access to care for millions of Medicare beneficiaries.

We continue to believe that MedPAC's rationale that half of MEI is sufficient because the practice expense component of physician payment accounts for approximately half of total Medicare physician payments reflects an incomplete picture of the cost of running a medical practice. It is well understood that the practice expense component does not cover all practice costs. For example, in the 2024 Medicare Physician Payment Schedule (MPS) proposed rule, the Centers for Medicare & Medicaid Services (CMS) apply a direct cost scaling adjustment of 0.4639. In other words, for a supply that costs $100, CMS will include $46.39 or a reduction of $53.61 from the invoice cost of the item in the direct expense allocation for the service. Additionally, practice expense is only one component of a multifactorial formula to compensate physicians for the total costs of running a medical practice and caring for Medicare beneficiaries. Payment for physician work—the time, energy, and expertise devoted to treating patients by physicians, nurse practitioners, physician assistants and other qualified health care professionals—is no less important, also contributes to total cost in the provision of a service and is equally impacted by inflation. Therefore, an inflation-based payment update is equally warranted for physician work and other aspects of total physician payment, all of which could be addressed by finalizing an update that is tied to full, rather than half, of MEI.

As the Commission pointed out, the gap between what Medicare pays physicians and the actual costs associated with delivering high-quality care continues to grow. Medicare physician pay has barely budged over the last two decades, increasing just 9 percent from 2001 to 2023, or just 0.4 percent per year on average. Part of this increase is attributable to a temporary 2.5 percent update in 2023 that will expire at the end of the year. By contrast, the cost of running a medical practice has increased 47 percent between 2001 and 2023, or 1.7 percent per year. When adjusted for inflation in practice costs, Medicare physician pay has declined 26 percent from 2001 to 2023, or by 1.3 percent per year on average. Next year, CMS projects the costs to run a medical practice will increase 4.5 percent, meanwhile, physicians face a 3.36 percent reduction to the Medicare conversion factor.

Physician practices cannot continue to absorb increasing costs while their payment rates dwindle. According to the Medicare Trustees, if physician payment does not change, access to Medicare-participating physicians will become a significant issue in the long term. Some Medicare patients are already experiencing inequitable delays in care, and we know that when care is delayed, health outcomes

worsen. These problems particularly impact minoritized and marginalized patients[1] and those who live in rural areas.[2] Will patients with Medicare have to wait six months to see a neurologist when they can no longer remember what day of the week it is? Will they have to wait eight months for an appointment with an oncologist about a persistent lump? Will they forego an endoscopy or mammography because the nearest gastroenterologist or radiologist who accepts Medicare is more than an hour away? Policymakers should intervene before these problems get any worse. **That is why the AMA is urging Congress to tie Medicare physician payment to the increase in MEI by passing H.R. 2474, the 'Strengthening Medicare for Patients and Providers Act.'**

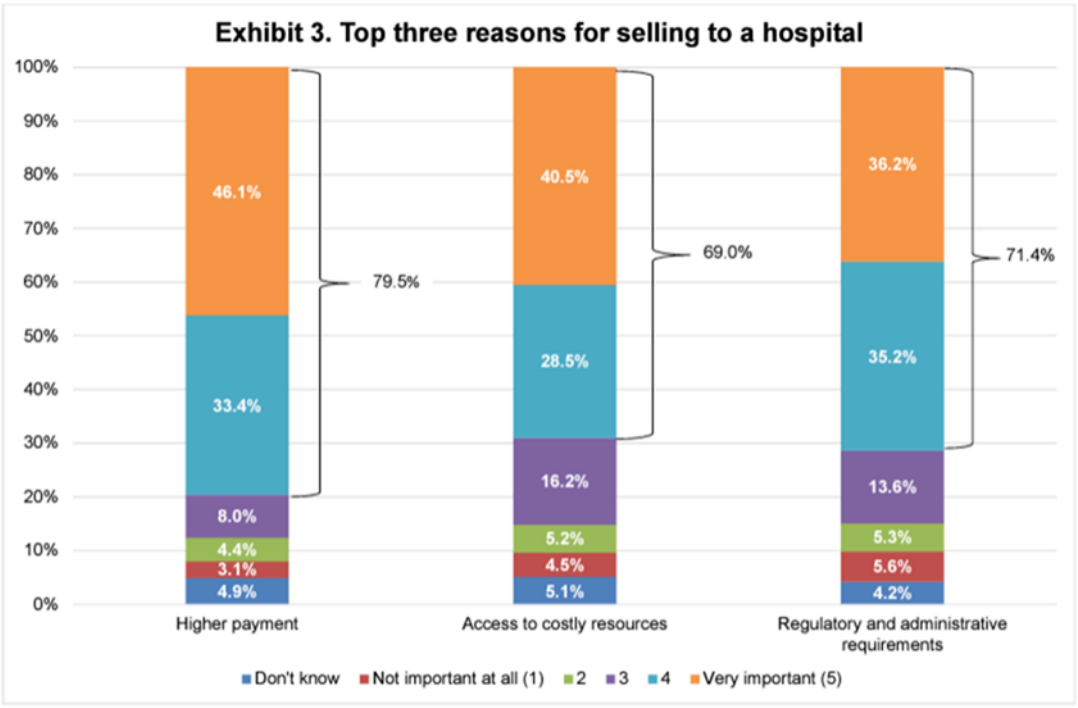
Furthermore, MedPAC discussed the site-of-service differential between physician practices and hospital outpatient departments (HOPDs). This differential stems in part from the absence of an annual inflation-based update to Medicare physician payment, unlike nearly all other Medicare providers. By contrast, Medicare hospital pay has increased roughly 70 percent between 2001 and 2023, with average annual increases of 2.5 percent per year for inpatient services and 2.4 percent for outpatient services. Unlike the proposal presented by MedPAC staff that would only update practice expenses paid under the Medicare Physician Payment Schedule by the hospital market basket, inpatient and outpatient payments are updated in full by the hospital market basket. Those payments also go toward paying physician salaries. One point that was not raised during the discussion is the effect of these differences in annual payment updates in the marketplace. Physicians who own and practice in independent offices must compete with HOPDs for the same clinician and non-clinical staff, equipment, and supplies, yet they are at a significant disadvantage as their payments have failed to keep pace with inflation.

Achieving site-neutral payments for outpatient services and procedures will require increases in Medicare physician payment, so that independent practices, which are often the most cost-effective setting, can be sustained and patient choice safeguarded. Many policy proposals over the years have recommended simplistic, across-the-board solutions to the site-of-service differential that reduce payments to all sites to rates paid in the least costly setting (i.e., lowering all services in the HOPD to MPS rates). However, the AMA does not believe it is possible to sustain a high-quality health care system if site neutrality is defined as shrinking all payments to the lowest amount paid in any setting. As a result, **the AMA advocates strongly that MedPAC recommend Congress allocate funds to the Medicare physician payment schedule to address increasing physician practice costs as measured by full MEI.**

As we discussed with MedPAC staff at our meeting last month, physicians are leaving independent practice and inadequate payment is the most cited reason that independent physicians sell their practices to hospitals, according to a new AMA analysis. The next most cited reasons were the need to better manage payers' regulatory and administrative requirements and the need to improve access to costly resources. Included below is an excerpted figure with more detail. The AMA strongly supports policies that promote market competition and patient choice. Payment adequacy is necessary for physicians to continue to have the ability to practice independently. The site-of-service differential and resulting trends are highly likely to increase future Medicare costs as other providers receive increasingly higher payments than the diminishing number of independent medical practices. The Administration has acknowledged that health care consolidation is leaving many areas, particularly rural communities, with inadequate or more expensive health care options.

[1] See e.g., Johnston KJ, Hammond G, Meyers DJ, Joynt Maddox KE. Association of Race and Ethnicity and Medicare Program Type With Ambulatory Care Access and Quality Measures. *JAMA.* 2021;326(7):628–636. doi:10.1001/jama.2021.10413.

[2] https://rhrc.umn.edu/wp-content/uploads/2019/12/UMN-Access-to-Specialty-Care_12.4.pdf.



Source: Author's analysis of AMA 2022 Physician Practice Benchmark Survey.
Note: These estimates are based on physicians whose practices had been acquired by a hospital or health system after 2012 and who were practice members at the time of that acquisition (N=282). The bracketed percentage is the sum of important (4) and very important (5).

2. Budget Neutrality Requirements Cause Large and Frequent Conversion Factor Cuts, Payment Redistributions Within the Medicare Physician Payment Schedule, and Permanent Reductions to Physician Payment

In addition to not keeping pace with inflation, Medicare physician payments are further eroded by frequent and large payment redistributions and cuts to the conversion factor caused by budget neutrality adjustments. Every year, the CMS makes changes in relative value units (RVUs) for some services because the billing codes used to describe a set of services have changed, technological advances cause new services to be added to the payment schedule, or more recently collected data indicate that services are either undervalued or overvalued. By law, any changes made within the payment schedule must be implemented in a budget neutral manner. Therefore, if CMS projects that net pricing changes for existing services across the MPS will increase (or decrease) total Medicare spending by more than $20 million, the agency must reduce (or increase) all Medicare physician services by that excess amount, typically by adjusting the Medicare conversion factor.

It is not uncommon for CMS to overestimate utilization in its budget neutrality estimates. The most prominent example of this was when transitional care management (TCM) services were added to the MPS in 2013. CMS estimated 5.6 million new claims would be submitted for these services. Actual utilization turned out to be just under 300,000 claims for the first year and was still less than one million claims after three years. As a result of this overestimation for TCM services alone, Medicare physician payments were reduced by more than $5.2 billion from 2013 to 2021. Once these redistributions are made through the conversion factor, they are not added back, even when utilization is lower than expected. The net result in these circumstances is not budget neutrality, but rather a permanent reduction in Medicare physician payments across-the-board.

More recently, Congress has had to intervene to avert double-digit budget neutrality cuts caused largely by the large payment increases for new evaluation and management (E/M) services. In the 2021 MPS proposed rule for example, CMS proposed to adopt the revised E/M coding guidelines and recommended values as put forward by the CPT Editorial Panel and the AMA/Specialty Society RUC, as well as retain the CMS-developed E/M add-on code, G2211. Combined with other coding revaluations, spending was projected to increase by over 10.2 billion dollars, necessitating a budget neutrality cut to the conversion factor of -11 percent.

This cut would be unreasonable at any time but particularly during the COVID-19 public health emergency, and Congress intervened by passing a temporary update to Medicare physician payment of 3.75 percent in 2021 and delaying implementation of the E/M add-on code until 2024. Congress continued to phase-in the budget neutrality cut by providing a 3 percent temporary update in 2022. Physicians again faced a steep budget neutrality cut in 2023 due to payment increases for other E/M code families, including hospital visits, nursing facility visits, and home health visits. In response, the Consolidated Appropriations Act of 2023 reduced an anticipated 4.5 percent cut by increasing the 2023 conversion factor by 2.5 percent, therefore reducing the cut to 2 percent.

Looking ahead at 2024, physicians are facing yet another large budget neutrality cut due to implementation of the E/M add-on code. CMS estimates that the conversion factor will be reduced by 3.36 percent in 2024. This cut, on top of previous cuts that are displayed in the table below, is untenable for physicians, particularly as it coincides with historic growth in inflation, which CMS anticipates will increase by 4.5 percent next year.

Year	**Conversion Factor (CF)**	**CF Percentage Change**	**MEI Percentage Change**
2020	$36.0896	0.14	1.9
2021	$34.8931	-3.3	1.4
2022	$34.6062	-0.80	2.1
2023	$33.8872	-2	3.8
2024 proposed	*$32.7476*	*-3.36*	*4.5*

In addition to providing an inflationary update, the AMA is urging Congress to redress the instability created by these large and frequent budget neutrality adjustments by taking the following actions:

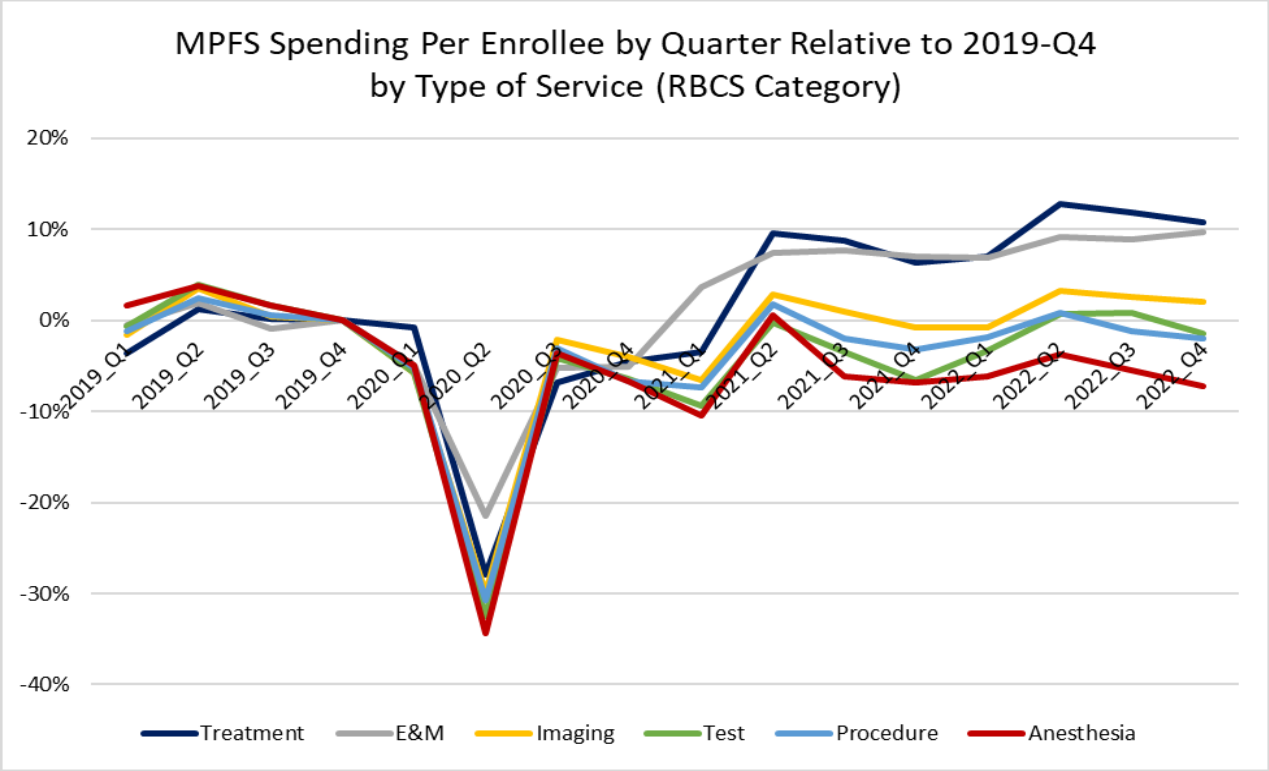
1. **Provide a lookback period to reconcile overestimates and underestimates of pricing adjustments for individual services.** This simple solution would allow for the Medicare conversion factor to be calculated with more accuracy based on actual utilization data.
2. **Refine which services are subject to budget neutrality.** Services for which utilization is expected to increase due to changes in federal policy should be exempt from budget neutrality. This should include newly covered Medicare services and technologies, high-value services that are being incentivized or intended to lower Medicare expenditures, and service expansions.
3. **Increase the budget neutrality trigger from $20 million to $53 million.** This $20 million threshold was established in 1992 and has not been updated since. Increasing the threshold to $53 million would allow for greater flexibility in making necessary pricing adjustments for individual services without triggering automatic, across-the-board Medicare cuts.

3. Drivers of Recent Growth in Medicare Physician Payment Schedule Spending

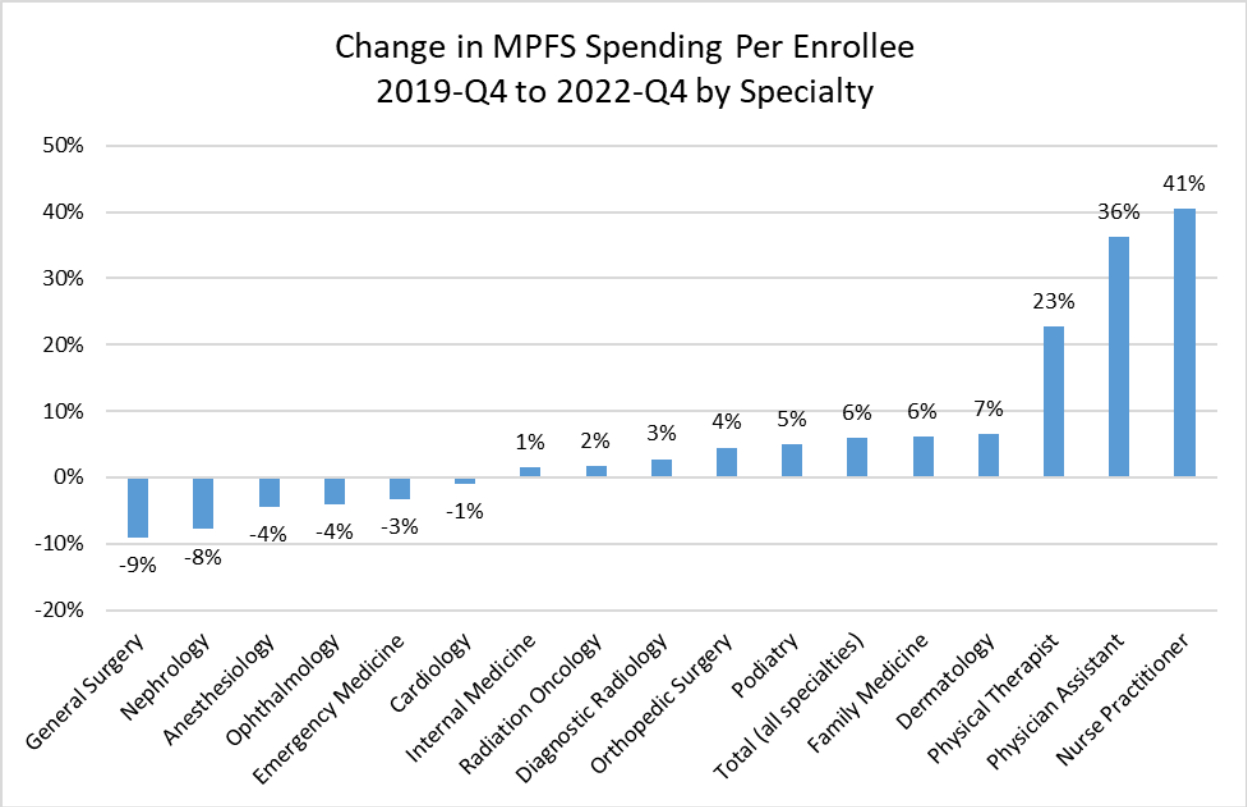
Recent data on Medicare Physician Payment Schedule spending trends at the specialty and service level do not support the comments made during the October meeting that growth in the volume and intensity of services furnished is being driven by growth in imaging, procedures, or physician behavior.

First, we wish to address an important omission on slide 12 of the presentation. Namely, the MPS spending per fee-for-service beneficiary line includes the temporary updates provided by Congress in 2021 and 2022, which expired at the end of those years. In 2021, Congress provided a temporary update of 3.75 percent and in 2022, Congress provided a temporary update of 3 percent to offset anticipated decreases to the conversion factor, as noted above. Both updates have since expired. While the notes indicate that these temporary updates do not appear in the red line, which is based on the growth in MEI, they are baked into the black line tracking spending, which is based on payment. We believe this is unclear from the presentation and should be clarified in any final materials.

Additionally, the AMA's analysis of quarterly Medicare data shows that spending growth is being driven by increases in payment for E/M services, as well as growth in spending by nurse practitioners (NPs), physician assistants (PAs), and physical therapists (PTs). In the chart below, which uses the Restructured **BETOS** Classification System to classify types of service, you can see spending per enrollee for E/M services increased sharply beginning in 2021 due to the large increases in pay that took effect that year, while spending per enrollee for other services increased slightly or declined. Spending per enrollee for treatments (e.g., physical therapy) increased 11 percent from the fourth quarter of 2019 through the fourth quarter of 2022, and E/M spending was up 10 percent. Spending per enrollee for imaging, procedures, and tests was roughly equivalent to pre-pandemic spending, but anesthesia spending per enrollee was still down 7 percent.



The chart below, also based on quarterly Medicare data, shows changes in spending by specialty. As you can see, Medicare Physician Payment Schedule spending per enrollee increased 23 percent between the fourth quarter of 2019 to the fourth quarter of 2022 for PTs, and by 36 percent and 41 percent, respectively, for PAs and NPs. Over this same time, MPS spending per enrollee by family medicine physicians increased six percent, which is driven in part by the large increase in pay for E/M services in 2021. By contrast, spending per enrollee by general surgeons and anesthesiologists decreased by 9 percent and 4 percent, respectively.



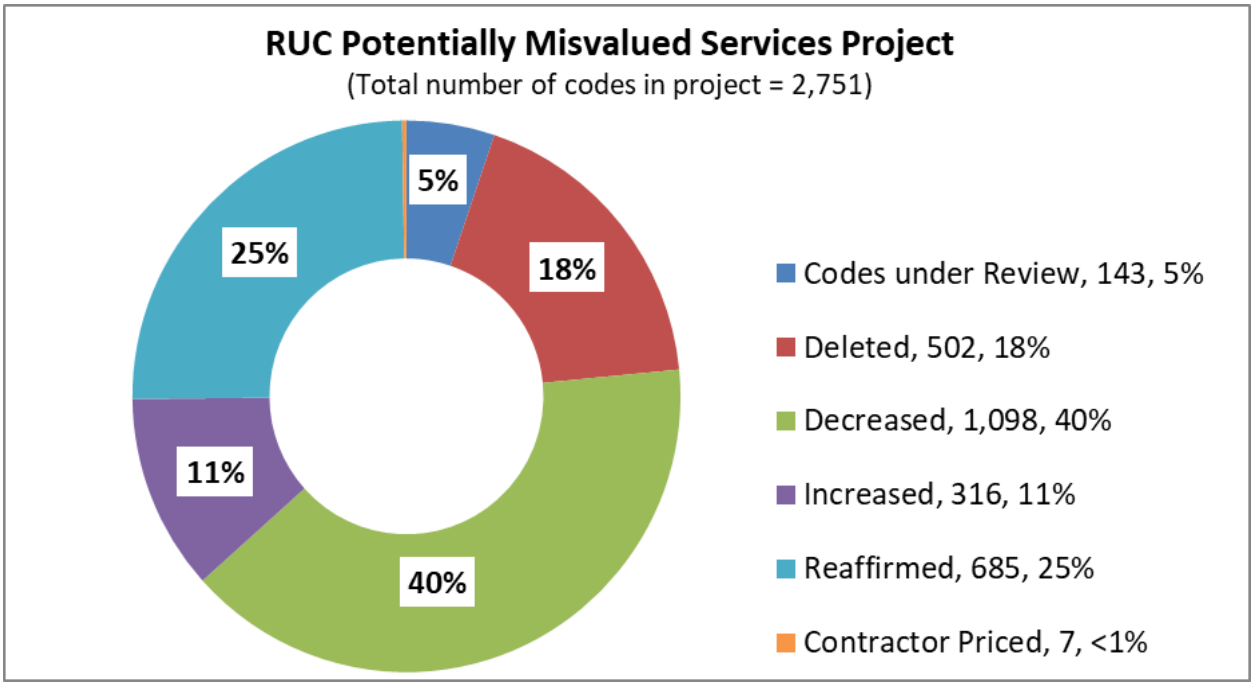
We appreciate the comments from commissioners regarding the importance of breaking down data by differences in specialty and practitioner type and urge MedPAC to look at more granular data, such as the information shown above, in future discussions about the growth in volume and intensity within the Medicare Physician Payment Schedule. It is clear that recent trends are not driven by growth in procedures and imaging or by physician behavior. Rather, data show that, beyond the recovery from the pandemic, the pay increase for E/M and growth in services provided by NPs, PAs, and PTs are the biggest drivers of recent growth in spending.

4. AMA/Specialty Society RUC's Extensive Work Addressing Potentially Misvalued Services

We wish to address another notable omission from the October 2023 meeting discussion, which is the extensive work done by the RUC to date to address misvaluations in the Medicare Physician Payment Schedule and the process for consistent, ongoing review of potentially misvalued services. In 2006, the RUC formed the Relativity Assessment Workgroup to proactively identify potentially misvalued services using objective mechanisms for reevaluation. In addition, the workgroup is also charged with developing and maintaining processes associated with the identification and reconsideration of the value of "new

technology" services. This workgroup was established by the RUC following comments from MedPAC urging CMS to demonstrate greater diligence in the identification of both potentially over- and under-valued services within the payment schedule for review during the five-year reviews.

Since 2009, the RUC has identified over 2,750 potentially misvalued services through objective screening criteria. The RUC has recommended that over half of the services identified be decreased or deleted (Chart 1).



The RUC has worked vigorously over the past several years to identify and address misvaluations in the **Resource-Based Relative Value Scale** through provision of revised physician time data and resources cost recommendations to CMS. The RUC fully acknowledges that there are services that are now performed more efficiently, and these codes have been or will be addressed. For example, the time and valuation for cataract surgery was significantly reduced in 2013 and again in 2020. The codes that have not been reviewed or re-reviewed by the RUC are low volume and represent less than three percent of Medicare Physician Payment Schedule allowed charges.

5. The MIPS is Plagued by Problems that Warrant Urgent Congressional Action

The AMA agrees with MedPAC that MIPS is fundamentally flawed. In its current form, MIPS is a repackaging of broken legacy reporting programs. CMS will highlight its efforts to change the program via the new MIPS Value Pathways (MVPs), but MVPs retain the same core rules and requirements of MIPS, despite physicians' recommendations for improvements and early participation in the development of MVPs. By carrying the flawed MIPS policies over into MVPs, CMS is doing the same thing and expecting a different result. Worse, as discussed below, there is a growing body of evidence that the program is disproportionately harmful to small, rural, safety net, and independent practices, as well as devoid of any relationship to the quality of care provided to patients. Moreover, physicians are largely stuck in MIPS as there are far fewer APM opportunities than anticipated when the Medicare Access and

CHIP Reauthorization Act of 2015 (MACRA) was passed..[3,4] Therefore, the AMA is strongly recommending that Congress make three key changes to MIPS to remedy these problems.

Background

CMS applied automatic MIPS hardship exceptions due to the COVID-19 pandemic in 2019, 2020, and 2021, and accepted applications for COVID-19 hardship exceptions in 2022 and 2023. While we supported these much-needed flexibilities, the program was severely disrupted for five years due to unforeseeable circumstances and, as a result, the gradual implementation of MIPS as originally envisioned by Congress in 2015 under MACRA was not realized. Meanwhile, CMS continues to rachet up the requirements as if the pandemic had never happened.

As MIPS requirements have continued to increase each year and the penalties (now at nine percent) apply in full, CMS expects a substantial rise in the number of physicians who will receive MIPS financial penalties. In the 2024 Medicare Physician Payment Schedule proposed rule, CMS estimates that over half (54 percent) of eligible clinicians (ECs) will receive a MIPS penalty averaging -2.4 percent in 2026. This is in large part due to the proposed increase to the number of points needed to avoid a MIPS penalty in 2024 (the number of points needed now stands at 82 points compared to just 15 points in 2018, the last year that MIPS was fully in effect before the COVID-19 automatic hardship exceptions took effect). Even more alarming, CMS estimates that nearly 65 percent of ECs in solo practices and 60 percent of ECs in small practices would receive a penalty, confirming that this program is penalizing small practices and redistributing those funds to large, well-resourced health systems. To be clear, there is no reason to believe that the disproportionately negative impact on small, rural, and safety net practices is due to differences in the quality or cost of care provided to Medicare beneficiaries. Rather, this discrepancy can be traced to the administrative burden of participating in MIPS, which has a disproportionate impact on these types of practices with fewer resources.

Additionally, we are hearing alarming reports that physicians are receiving penalties in 2024 for the first time in the program, which will compound the proposed -3.36 percent reduction to the conversion factor. **We have serious concerns that a lack of awareness of the expiration of the automatic COVID-19 flexibilities unfairly penalizes physician practices and disproportionately impacts small, independent, and rural practices.**

Major changes to and issues with the cost category are compounding these concerns. Practices that were historically successful in the program are now expected to receive a penalty in 2024 due to the cost category now being calculated for the first time and weighted at 30 percent of MIPS final scores. The impact of the cost category is shocking to most physicians since the measures were not calculated in the two prior performance years due to COVID-19. Physicians had no way to anticipate, monitor, or improve their 2022 cost performance category score because CMS did not share any data about attributed measures, patients, or observed costs until August 2023—more than eight months after the conclusion of the performance period. Furthermore, there were errors in CMS' code and measure specifications in the cost category that we anticipate will contribute to the number of physicians who will receive penalties.

[3] Setting value-based payment goals--HHS efforts to improve U.S. health care. Sylvia M. Burwell. N Engl J Med. March 2015.
[4] APM Measurement: Progress of APMs. 2020-2021 Report. Health Care Payment Learning & Action Network.

As a possible solution to lessen the 2024 payment cuts, the AMA strongly urged CMS to extend the October 9, 2023, deadline to appeal a MIPS payment penalty and to permit physicians to apply for a COVID-19 hardship exception as part of their Targeted Review request. There is CMS precedent to utilize the Targeted Review process to claim extreme and uncontrollable circumstance (EUC) due to the Public Health Emergency (PHE). Prior to CMS automatically applying the EUC to 2019 performance/2021 payment adjustments, CMS allowed practices to file a 2020 Targeted Review and claim the PHE. Unfortunately, CMS held strong to their deadline and ignored our plea and a potential solution.

In addition to the concerns about the significant increases in MIPS penalties starting in 2024, there is mounting evidence that the program as currently implemented is causing significant administrative burden, raising costs for physician practices, and disadvantaging small, independent, and rural practices, all with no proven improvement on quality outcomes. In fact, the program may be exacerbating health inequities by negatively impacting practices that serve medically underserved populations. In summary:

- **MIPS disadvantages rural and medically underserved populations.** According to the U.S. Government Accountability Office (GAO), practices serving rural and medically underserved patient populations face numerous challenges participating in MIPS, including lack of technology vendor support, high costs of ongoing investments needed for participation, staffing shortages, and challenges staying abreast of changing program requirements. According to another GAO report, similar challenges limit rural practices' abilities to transition to APMs.
- **MIPS does not correlate with improved quality of care.** A 2022 study in *JAMA* found that MIPS may not even correlate with the quality of care delivered and that physicians caring for more medically or socially vulnerable patients were more likely to receive low scores despite providing high-quality care.
- **MIPS is administratively burdensome and costly.** Researchers found it costs $12,811 and 201 hours per physician, per year to comply with the complex and ever-changing MIPS requirements, and, on average, physicians themselves spent more than 53 hours per year on MIPS-related tasks. These 53 hours are equivalent to a full week of patient visits. The researchers found that the majority of the MIPS activities included reviewing medical records, collecting information from patients, and entering data into the EHR.
- **MIPS disadvantages small and independent practices.** Based on our analysis of 2021 MIPS performance data, three times as many clinicians in small practices had MIPS scores resulting in penalties – 11.9 percent versus 3.36 percent overall. Further, according to a study in *JAMA*, affiliation with a health system was associated with significantly better 2019 MIPS performance scores.
- **MIPS disadvantages safety net practices and exacerbates health inequities.** According to a study in *JAMA* that looked at the first year of MIPS, physicians with the highest proportion of patients dually eligible for Medicare and Medicaid had significantly lower MIPS scores compared with other physicians.

Finally, the AMA has serious concerns about the lag in MIPS feedback data shared with physicians, as well as discrepancies in the MIPS public use files. Currently, CMS provides physicians with an annual MIPS Feedback Report that includes information about their performance on MIPS metrics six to 18 months after they have provided a service to a Medicare patient. As a result, physicians do not know either at the time they provide services or at any point during the performance year how they are performing on any of the cost measures that collectively account for 30 percent of their total MIPS score, including which cost measures they will be measured on, which patients are attributed to them, and for

what costs or services provided by other health professionals or facilities outside of their own practices they will be held accountable. The lack of meaningful timely data also impacts the administrative claims quality measures in the quality category, which CMS continues to add on top of the other quality requirements. Without this information, physicians have no way to monitor their performance, identify opportunities for efficiencies in care delivery, and avoid unnecessary costs or improve care coordination.

Furthermore, following an in-depth analysis of the 2021 Quality Payment Program (QPP) Provider Data Catalog, we have found that the files have major completeness and consistency issues. As a result, not only is it difficult to drill down in the data to better understand how small practices and rural practices, for example, are performing in MIPS and why this might be the case, it brings into question the fundamental accuracy of the data used to calculate MIPS scores. Ensuring this data is accurate is critically important to accurate payment adjustments as well as ongoing efforts to better understand and improve this program, which should be a shared goal of physicians, CMS, and MedPAC.

Specifically, there is one file that contains the MIPS scores for each clinician but does not have any information about the clinician other than their name and national provider identifier (NPI). The National Downloadable File that accompanies this MIPS score file has information about clinicians, such as their specialties and the names of the group or groups with which they practice. However, we have found that there are almost 100,000 NPIs with a MIPS score that are not included in the National Downloadable File. We looked at the 2020 files, and the same problem exists there. In 2020, there were 180,000 NPIs that have a MIPS score that are not in the National Downloadable File. When we looked in the CMS Enrollment File data for that same time period, there were several thousand NPIs with MIPS scores that were not in the Enrollment File. We are strongly urging CMS to explain and correct these inconsistencies between data files, particularly regarding why so many NPIs are missing from the National Downloadable File, and to instruct physicians how to otherwise access this important data.

Recommendations

While CMS has tried to improve the program, such as by introducing the MIPS Value Pathways (MVPs) option, these changes are largely superficial as the agency believes it does not have statutory authority to remedy more significant structural problems directly. Congress must step in and act to prevent unsustainable penalties, particularly on small, rural, and underserved practices; help practices transition to value-based care; and increase overall transparency and oversight in the program. Below we offer three legislative changes that would help to streamline and improve the program, drive quality improvements, and reduce negative impacts on small, rural, and safety net practices, all while reducing unnecessary burden on physician practices.

1. **Congress should mitigate steep MIPS penalties following the COVID-19 pandemic that disproportionately harm small, rural, independent practices and practices that care for the underserved and allow practices to revitalize quality improvement infrastructures.**

To accomplish this aim, the MACRA statute should be amended to:

- **Freeze the MIPS performance threshold for three years** to prevent steep penalties and allow practices to continue to recover from the effects of the pandemic and transition back to MIPS following a five-year interruption due to COVID-19. Importantly, this would also allow CMS time to implement and educate practices on legislative improvements to the program. Congress should use the 2021 performance threshold of 60 points (out of 100), which CMS established as a transitionary policy to encourage participation on all MIPS measures.

- **Eliminate MIPS win-lose style payment adjustments and instead link physicians' MIPS performance to an annual inflation-based payment update (e.g., tied to MEI).** Specifically, physicians could be subject to up to a one-quarter reduction in their update based on their MIPS performance, which would be consistent with the Hospital Inpatient Quality Reporting (IQR) Program.
- **Reinvest money from penalties both in bonuses for high performers, as well as investments aimed at assisting under-resourced practices with their value-based care transformation,** with an emphasis on small practices, rural practices, and practices that care for underserved patients.

2. Congress should hold CMS accountable for timely and actionable MIPS and claims data.

Congress recognized the importance of timely data to drive performance improvement, which is why it originally mandated under MACRA that CMS must provide timely (i.e. quarterly) MIPS quality and resource use feedback, as well as claims data to physician practices, similar to the types of data provided to Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs).[5] Despite this requirement, physicians did not receive their most recent MIPS Feedback Report based on 2022 performance from CMS until August 2023. These reports are also high-level summary reports.

While CMS also produces an overall program QPP Experience Report, it is of limited use. For example, the same physician can be counted multiple times if they bill for services through multiple organizations. The same physician can have a low MIPS score for one practice and a high MIPS score for another. On top of that, CMS does not break down performance by physician specialty, site of service, or the type of reporting. The report also fails to show any longitudinal trends about whether quality or cost are getting better or worse, nor does it provide a complete picture of what made a physician or group practice successful in MIPS. Combined with the completeness and consistency issues noted above, it is difficult to drill down into the data to draw key insights, such as better understanding the challenges facing small practices and rural practices, for example.

No physician in MIPS has ever received Medicare claims data similar to what MSSP ACOs receive, which includes Medicare Parts A, B, and D claims data for their assigned beneficiaries. This means that physicians do not know in real time or even on a quarterly basis which cost measures are being attributed to them, which patients are being assigned to them, and what costs outside of their practice they are being held accountable for until well after the performance year is already over, making it impossible for them to leverage this data to implement changes that would improve patient care, outcomes, and use resources more efficiently, saving costs.

Accordingly, the AMA is urging Congress to exempt from penalties any ECs who do not receive at least three quarterly MIPS feedback and claims data reports during the performance period.

3. Congress should make MIPS more clinically relevant while reducing burden.

As discussed above, MIPS is unduly burdensome and has not been shown to improve clinical outcomes or reduce unnecessary costs. Moreover, the program does not prepare physicians to move to APMs. Therefore, our third and final recommendation, is to amend the statute to solve these problems by:

[5] §42 USC 1395w-4(q)(12).

- **Removing siloes between the four MIPS performance categories** to allow for multi-category credit, therefore reducing burden.
- **Aligning MIPS requirements with those for other CMS value-based programs** to minimize reporting burden, align quality and cost goals, and better support care provided in hospitals and other care settings.
- **Reforming the Promoting Interoperability (PI) requirements** to recognize the value of clinical data registries and other promising new technologies by allowing physicians to attest to using certified EHR technology (CEHRT) or technology that interacts with CEHRT, participation in a clinical data registry, or other less burdensome means. Notably, attestation of using CEHRT is consistent with the hospitals' requirements in Promoting Interoperability, as well as current APM requirements.
- **Enhancing measurement accuracy and clinical relevance, particularly within the cost category,** to target variability that is within the physician's ability to influence.
- **Aligning cost and quality goals.** MIPS rarely evaluates quality and cost on the same patients and for the same conditions, which has been a key factor inhibiting its ability to drive clinical improvement. Quality and cost measures are developed in isolation of one another and use different patient populations, attribution methodologies, and risk adjustment methodologies. Harmonizing these measures would ensure MIPS is driving high-value care as intended while reducing burden on physician practices.
- **Improving quality measurement accuracy** by awarding credit for testing new or significantly revised measures, including QCDR measures, for up to three years.

The AMA strongly believes that each of these policy changes is essential to improve the clinical relevance of MIPS, provide a bridge to transition to APMs, and promote the intended goals of MACRA to leverage health information technology, improve quality, and reduce Medicare costs all while reducing burden on physician practices.

6. Continued APM Incentive Payments are Necessary to Expand APM Development and Physician Participation

Advancing the movement to value-based care in Medicare by implementing APMs for physician services was an important goal of MACRA. Value-based care links payments for services provided to patients to the results that are delivered, such as the quality, equity, and cost of care. APMs are a key approach to achieving value-based care by providing incentive payments to deliver high-quality and cost-efficient care for a clinical condition, a care episode, or a patient population. There are various types of APMs, including accountable care organizations (ACOs), bundled payment models, primary care medical homes, and others.

The creation of the Center for Medicare & Medicaid Innovation (CMMI) and the Medicare Shared Savings Program (MSSP) aimed to provide a significant boost to Medicare APMs. CMMI was established to test new APMs and the MSSP allowed for the development of Medicare ACOs in which medical practices and hospitals or health systems work together to coordinate all care for a defined patient population. When Congress enacted MACRA in 2015, there were still too few APMs for physician services available, so Congress included an APM pathway and six years of incentive payments. Congress also recognized that to be successful, APMs need to be designed by physicians working on the front lines of care, so MACRA included the Physician-focused Payment Model Advisory Committee (PTAC) to review and recommend stakeholder-designed APM proposals.

Currently, there are far fewer opportunities for physicians to participate in Medicare APMs than Congress envisioned under MACRA. While the goal was to provide opportunities for the majority of physicians to transition into APMs, CMMI models implemented to date often have steep financial risk requirements, lack funding needed to successfully redesign care delivery, and are usually only available in selected regions. In addition, because these APMs must demonstrate savings for Medicare within a short timeframe, they are often terminated instead of being improved and expanded nationwide. In a report on practices in rural or underserved areas, the GAO noted that many lack the capital to finance the upfront costs of transitioning to an APM and face challenges acquiring or conducting data analysis necessary for participation. Although the newest primary care medical home model in Medicare, called Making Care Primary, has many promising features, there is also no nationwide primary care medical home model in Medicare, so patients are not benefiting from the improvements in preventive care, health care quality, and management of chronic conditions that medical homes can provide.

A great source of frustration to the physician community is that, despite the many stakeholder-developed APMs recommended by the PTAC for testing or implementation, no Medicare APMs have been adopted from the PTAC proposals or developed by CMMI to help specialists improve care for patients with chronic diseases like rheumatoid arthritis, heart failure, chronic obstructive pulmonary disease, or inflammatory bowel disease, or patients who would benefit from innovations in surgical care. Instead of keeping patients healthier and preventing hospitalizations, the CMMI-developed APMs have largely focused on services provided to patients after they have already been admitted to the hospital or begun treatment such as chemotherapy. As a consequence, Medicare patients, especially those outside of the hospital setting, are missing out on the benefits of APMs, including more timely and accurate diagnosis, improved patient-physician shared decision making about treatment plans, preoperative rehabilitation, as well as savings from enhanced care coordination and smarter choices about when to use biologics and other therapies.

CMMI needs to update its criteria for adopting and expanding Medicare APMs. For example, requiring APMs to achieve Medicare savings within a very short time span has led multiple medical home and other models to be terminated and limited adoption of specialty models. Meaningful pathways are needed for APM proposals developed by stakeholders, including those recommended by the PTAC, to be implemented in Medicare.

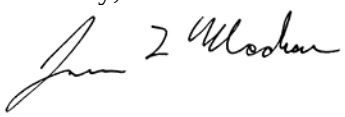
One result of the paucity of APMs for people with Medicare that reflect the experience of frontline practicing physicians has been that the APM incentive payments provided under MACRA to support physicians transitioning to APMs have reached far fewer physicians than had been forecast. In addition, MACRA requires sharp increases in the threshold percentages of APM participation for physicians to qualify for the APM incentive payments, but most APM participants cannot attain the higher thresholds.

It is clear that significant changes are needed to realize the robust pathway to APMs that Congress envisioned. This is why the AMA and physician organizations support the ‘Value in Health Care (VALUE) Act,’ H.R. 5013, which is bipartisan legislation that would:

- Reauthorize crucial incentive payments to increase physician participation in Advanced APMs before they expire at the end of 2023.
- Make participation thresholds for earning the incentive payments more flexible and realistic, thus preventing abrupt increases scheduled to take effect in 2024.

The AMA appreciates MedPAC's attention to opportunities to correct the current deficiencies of the current Medicare physician payment system and thanks the Commission for its consideration of our input on these topics. If you have any questions regarding this letter, please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,



James L. Madara, MD