James L. Madara, MD
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December 18, 2023

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: Merit-based Incentive Payment System Cost Performance Category

Dear Administrator Brooks-LaSure:

On behalf of our physician and medical student members, the American Medical Association (AMA) strongly urges the Centers for Medicare & Medicaid Services (CMS) to immediately address serious, unintended problems with the Merit-based Incentive Payment System (MIPS) Cost Performance Category. **Specifically, we reiterate our strong recommendation that CMS reweight the 2022 Cost Performance Category to zero percent of MIPS final scores to nullify the negative impact of the problematic measures on 2024 Medicare physician payment prior to January 1. CMS should also resolve the problems with the Cost Performance Category for 2023 and future performance years.**

The AMA urges CMS to immediately reweight the 2022 Cost Performance Category to zero percent of final MIPS scores due to problems with the application of the methodologies that are resulting in unintended, inaccurate, and dubious outcomes, such as measuring radiologists on their primary care costs, as well as problems with the underlying data sources, including the use of expired and deleted Current Procedural Terminology® (CPT®) codes. Therefore, **we strongly believe the agency has the authority to do so given the agency's authority to reweight the category rests on a finding that the data is "inaccurate, unusable, or otherwise compromised due to circumstances outside the control of the clinician and its agents."[1]** The following examples repeatedly demonstrate that the standard, which we will call the "reweighting standard," is exceeded by the problems physicians and the AMA have identified with this category.

Problems with the 2022 Cost Measures

First, since CMS released the 2022 MIPS Performance Feedback Reports to physicians in August, the AMA has heard a growing chorus of concerns about the unintended and nonsensical consequences of the cost measures, such as an interventional cardiologist who participated as an individual being held accountable for the costs of managing patients' diabetes care. The AMA documented these problems in an October 27, 2023 letter, to CMS and since then we have been notified of additional concerns with the 2022 MIPS Cost Performance category. Given we are near the end of 2023, there is an urgency to notify

[1] 42 CFR 414.1380(c)(2)(i)(A)(9).

you of the additional problems prior to 2022 MIPS performance period penalties taking effect on January 1, 2024, including:

1. The AMA is concerned 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. *In this example, the reweighting standard is met because the data is not only inaccurate but also compromised as the data is artificially reducing the benchmark based on a lie (i.e., surgery can happen outside an operating room) in the resulting score for this physician.*

2. The AMA is concerned that the melanoma resection measure is making apples-to-oranges comparisons. We learned that dermatologists who are receiving referrals appear to be higher spending 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 appears to be higher spending due to the differences in diagnosis coding. *Here, the reweighting standard is met because the data is inaccurate as it fails to account for differences in coding, which appear in the scores as differences in costs.*

3. The AMA wishes to reiterate reports we have heard about erroneous attribution of the chronic condition episode-based cost measures. We have heard many examples of specialists who are not primary care physicians and do not assume the care for diabetes, asthma, or COPD conditions being attributed the costs of these conditions. For instance, ophthalmologists attributed the diabetes episode-based cost measure in 2022. While CMS fixed this problem for 2023 and future years, the agency is currently allowing this problematic attribution flaw to affect Medicare reimbursement to ophthalmologists in 2024. *In this case, the reweighting standard is met as CMS has acknowledged that the attribution data logic resulted in an inaccurate outcome, which is being fixed for 2023 but not for 2022.*

4. The AMA heard that oncologists are being attributed both the Diabetes and Asthma/COPD episode-based cost measures. We have heard from oncologists in oncology groups (including medical, surgical, radiation, and gynecologic oncologists, as well as urologists and hematologists) who have multiple visits with patients during the performance period and may include ICD-10 codes related to complications of these conditions as they impact and may alter the course of chemotherapy and other oncology treatments. However, an oncologist including significant complications of care in billing for oncology-related visits should not result in attribution of non-oncology cost episodes. This will result in skewed benchmarks and unfair penalties on

> oncologists who have much higher spending on cancer care than physicians who are managing patients' diabetes or COPD in the absence of cancer. We are further concerned that unfairly penalizing oncologists is detrimental to the Administration's Cancer Moonshot, as any MIPS penalty would not only apply to cancer care but also the newly finalized G-codes for patient navigation. *Again, the reweighting standard is met because the benchmark data now inaccurately includes the costs to diagnose and treat cancer, rather than diabetes and asthma/COPD.*

In its response to the AMA's October 27 letter, which is attached in Appendix B, CMS blames the attribution errors on group reporting and states that cost measures are just like quality measures as "a clinician may be scored for a quality measure that is outside the specific care they provide." Physicians understand the trade-offs between group and individual participation for quality measures, including a lower reporting burden and higher reliability for group reporting versus the potential for selecting more clinically relevant measures at the individual clinician level. However, the cost measures are not like the quality measures in this regard as neither the group nor the individual can select which cost measures to be measured on. Rather, CMS performs all cost measure calculations on the back end and that information is not currently shared with individuals or groups until eight months after the performance period ends. Therefore, physicians and groups cannot weigh the trade-offs for individual versus group reporting for cost measures because they have no idea which cost measures they will be scored on at either the individual or group level due to the complete silence from CMS about patient attribution and cost measure assignment during the performance period. Because CMS provides no timely or actionable information to physicians on the cost measures that they are being held accountable for, this leads to inaccurate, misleading, and compromised results that are outside the control of the physician being measured and ultimately penalized.

Group reporting does not explain away the nonsensical problems with the attribution of the Total Per Capita Cost Measure (TPCC) and the chronic condition episode-based cost measures. For instance, we fail to see the similarities between a radiology practice that is measured on the primary care focused TPCC because the nurse practitioners and physician assistants in the group provide visits to complex interventional radiology patients, thus triggering attribution, and a multi-specialty group that elects to report six primary care quality measures. Rather, we believe this inaccurate result (and the other inaccurate results outlined above) prove the cost measures are not operating as specified.

Invalid Codes Used in the 2022 Cost Measures

Second, the AMA remains concerned that CMS did not use the most updated CPT codes for its TPCC and Medicare Spending Per Beneficiary (MSPB) measure specifications in 2022. As previously noted in our 2024 Medicare Physician Payment Schedule proposed rule comments, the AMA reviewed the coding specifications currently posted to the Quality Payment Program (QPP) website for 2023 and found that the coding specifications for the TPCC and MSPB have not been updated since 2020 (see Appendix A). While the CPT code set is updated yearly, the evaluation and management (E/M) section of the code set went through substantial updates in 2021 and 2023. As these codes specifically are a large component of these cost measures, it is essential to ensure that these changes to the codes are reflected in the coding specifications. Maintaining measure specifications and ensuring that they are up to date for the measurement period being evaluated is a basic piece of measure development and maintenance and speaks to not only face validity of the measures, but also to correct measure calculation.
In addition, the AMA has identified the several additional discrepancies between the 2022 CPT code set and the measure specifications, including:

- CPT Code 99201 was deleted effective January 1, 2021, but remains in the measure specifications (See Appendix A).
- There is an incomplete CPT metric selection, which is seen in the 2022 TPCC Codes list (see Appendix A). CMS G codes for Initial Preventive physical Examination and wellness visit were included, but analogous codes from CPT for Preventive Medicine Services for new and established patients in the appropriate age ranges (CPT codes 99386, 99387, 99396 and 99397), all of which were established in 2009, were not included. Therefore, the underlying base patient population selected is incomplete.
- CPT codes 69716, 69717, 69719, 69726, 69727, all codes pertaining to Osseointegrated Implants, with 90-day global periods and modified effective January 1, 2022, are not using accurate codes and descriptors (see Appendix A). There is a disproportionate impact on the specialty of Otolaryngology Surgery with these omissions and lack of use of updated codes.
- Finally, the CPT codes 69728, 69729, and 69730, which were effective January 1, 2023, with 90-day global periods, are not included in the base data selection list (see Appendix A). While this example applies to the 2023 performance period, we believe it is important as it illustrates that using old code sets results in inaccurate and incomplete data and that problems are poised to continue going forward unless CMS and the measure developer intervene to update the underlying code set for the cost measure specifications.

It is important to note that the CPT Code Set has had 1,061 changes for the 2021 through 2023 time period across all CPT code areas. Failure to use the proper set of current CPT codes added, deleted and/or modified since 2020 will impact any measure set that uses CPT codes in patient selection criteria, with the potential for significant and material inaccurate and/or incomplete base and performance data across a wide range of specialties. All measures that utilize CPT codes in patient selection criteria need to be reviewed and updated to ensure that the patient populations and subsequent performance are accurately representing performance during both the base and performance measurement periods.

Also note that the Measure Information Form (MIF) for the 2022 Total Cost Per Capita cost measure appears to not be consistent with the specifications included in the specification spreadsheet for the measure. Appendix B of the MIF includes CPT E/M codes to designate what would be considered "primary care." The copyright included and the listed code descriptors are from CPT 2019, which is yet another specification inconsistency. Additionally, CPT E/M codes are not only utilized by primary care physicians. Any physician or other qualified health care professional (including specialists) may report these E/M codes as they are appropriate to their practice. Labeling CPT E/M codes as "primary care" is misleading.

In CMS' response to the AMA's October 27 letter (see Appendix B), the agency states the measure developer considers whether revised codes necessitate updates to the measure specifications and believes that "[c]hanges to billing guidance and code descriptions that do not alter the clinical relevance of the services to the measure do not require updates to the specifications." **CMS implies that the changes to the office and outpatient E/M codes did not "alter the clinical relevance of the services to the measure" and thus were not updated; however, the agency offers no specifics about its rationale or any data analysis, such as a comparison of the pre-2021 measure specifications and post-2021 measure specifications. We do not believe that physicians should be required to accept that the historic changes to the CPT code set made in 2021 do not have any implications to the measures without any explanation. This was not a typical code change; these were sweeping revisions to codes that had not been touched in 30 years.** Furthermore, the AMA disagrees that it should be within the purview of the measure developer alone to update the coding changes within the measure specifications,

and, at a minimum, we believe there should be some type of communication back to the entity that is responsible for maintaining the code set to verify the intent and accuracy.

CMS goes on to state that the agency is continuing to include codes that CPT and CMS deleted in 2021 that are "still being billed in a significant manner in 2021 and 2022. At this time, there is no evidence that their continued inclusion impacts the reliability or validity of the measure or how the measure score is calculated; however, there is evidence to suggest that removing these codes could fail to capture applicable episodes." CMS provided no information about which deleted CPT codes continue to be billed "in a significant manner." Despite this lack of transparency, the inclusion of deleted codes raises serious concerns. If the measures include deleted codes that presumably are being bounced back to the physician for reprocessing, then there is the potential unintended consequence to include the same service twice – once based on the claim with the expired code and again with the reprocessed claim with a correct code. Furthermore, we believe that the administrative claims measures, which are merely algorithms, are only as good as the data that is being used. **If the data that CMS is using to determine an episode of care or attribution is based on deleted or expired codes, that calls into serious question the validity of the entire measure. In other words, one inaccurate code is corrupting the entire measure.** *Thus, the reweighting standard is also met with respect to the inaccurate CPT coding in the TPCC and MSPB Clinician measures.*

CMS Should Reweight the 2022 Cost Performance Category to Zero and Fix the Problems Going Forward

Because the reweighting standard is satisfied and the cumulative effect of these problems is to cast substantial doubt on whether the MIPS cost measures are fairly and accurately assessing variations in costs within the control of physicians as intended, we strongly urge CMS to reweight the Cost Performance Category to zero for the 2022 performance period before the MIPS payment adjustments take effect on January 1. Physicians' Medicare payment should not be reduced based on questionable measures that use out-of-date CPT coding, inaccurate data, or faulty methodologies. The nonsensical examples that we outlined above, which we believe to be only the tip of the iceberg based on the limited data available at this time, prove that the 2022 cost measures cannot be saved with bandages. Rather, these problems call for a solution that will meet the moment – reweighting them to zero to negate their negative impact on Medicare payment.

CMS cannot afford to continue to ignore the problems with these measures and their impact on physicians. MIPS is under growing scrutiny from both Congress and the Medicare Payment Advisory Commission. The program's immense administrative burden places small, rural, medically underserved, and independent practices at a steep disadvantage. A 2022 study in *JAMA* found that MIPS scores are inconsistently related to performance, and physicians caring for more medically and socially vulnerable patients were more likely to receive low scores despite providing high-quality care. Rather than cement another flaw in the program, CMS should use its authority to reweight the 2022 Cost Performance Category and get it right before moving ahead with cost measures.

Looking ahead, **we strongly urge CMS and its measure developer to clearly and transparently address how it will remedy the problems with these measures before the 2023 performance period feedback is released. We recommend that the agency release a fact sheet or Frequently Asked Questions document outlining the steps taken to ensure that the cost measures are not unduly and unfairly penalizing physicians for costs outside of their control and outside the intended specifications of the measure.** The AMA stands ready to convene our partners in the house of medicine to work with CMS toward this important advancement.

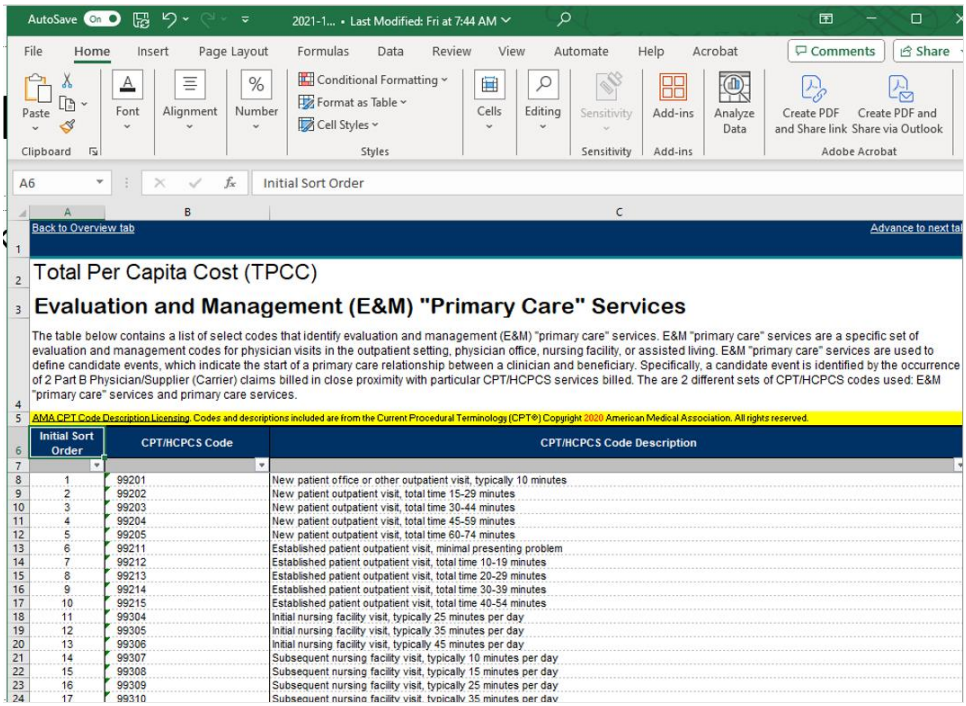
Thank you for considering our request and taking the necessary steps to better ensure that the MIPS Cost Performance Category does not unfairly penalize physicians. Please do not hesitate to contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org with any questions or to discuss further.

Sincerely,

James L. Madara, MD

Attachment

Appendix A



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Total Per Capita Cost (TPCC)

Evaluation and Management (E&M) "Primary Care" Services

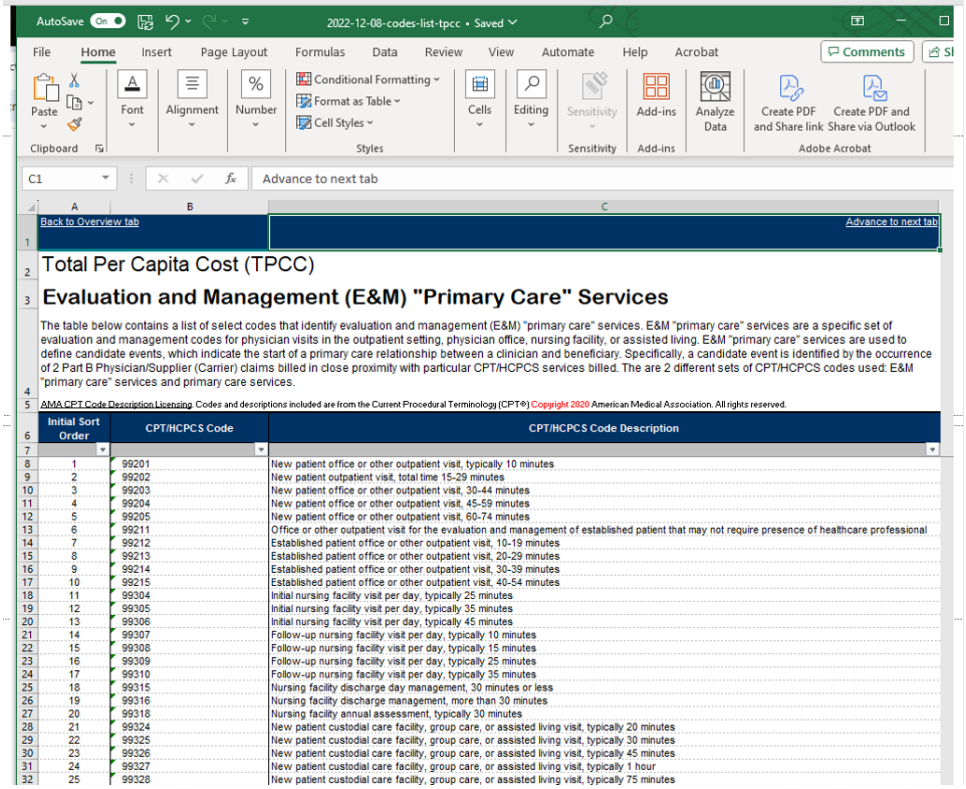
The table below contains a list of select codes that identify evaluation and management (E&M) "primary care" services. E&M "primary care" services are a specific set of evaluation and management codes for physician visits in the outpatient setting, physician office, nursing facility, or assisted living. E&M "primary care" services are used to define candidate events, which indicate the start of a primary care relationship between a clinician and beneficiary. Specifically, a candidate event is identified by the occurrence of 2 Part B Physician/Supplier (Carrier) claims billed in close proximity with particular CPT/HCPCS services billed. The are 2 different sets of CPT/HCPCS codes used: E&M "primary care" services and primary care services.

AMA CPT Code Description Licensing: Codes and descriptions included are from the Current Procedural Terminology (CPT®) Copyright 2020 American Medical Association. All rights reserved.

Initial Sort Order	CPT/HCPCS Code	CPT/HCPCS Code Description
1	99201	New patient office or other outpatient visit, typically 10 minutes
2	99202	New patient outpatient visit, total time 15-29 minutes
3	99203	New patient outpatient visit, total time 30-44 minutes
4	99204	New patient outpatient visit, total time 45-59 minutes
5	99205	New patient outpatient visit, total time 60-74 minutes
6	99211	Established patient outpatient visit, minimal presenting problem
7	99212	Established patient outpatient visit, total time 10-19 minutes
8	99213	Established patient outpatient visit, total time 20-29 minutes
9	99214	Established patient outpatient visit, total time 30-39 minutes
10	99215	Established patient outpatient visit, total time 40-54 minutes
11	99304	Initial nursing facility visit, typically 25 minutes per day
12	99305	Initial nursing facility visit, typically 35 minutes per day
13	99306	Initial nursing facility visit, typically 45 minutes per day
14	99307	Subsequent nursing facility visit, typically 10 minutes per day
15	99308	Subsequent nursing facility visit, typically 15 minutes per day
16	99309	Subsequent nursing facility visit, typically 25 minutes per day
17	99310	Subsequent nursing facility visit, typically 35 minutes per day

Seen in the screen shot above are the 2022 Performance Measure specification for Total Per Capita Cost measure.[2] AMA Copyright indicates the year 2020. **CPT Code 99201 was deleted effective January 1, 2021.**

[2] 2022 E&M "Primary Care" Services List accessed on December 13, 2023 from https://qpp.cms.gov/mips/explore-measures?tab=costMeasures&py=2022.



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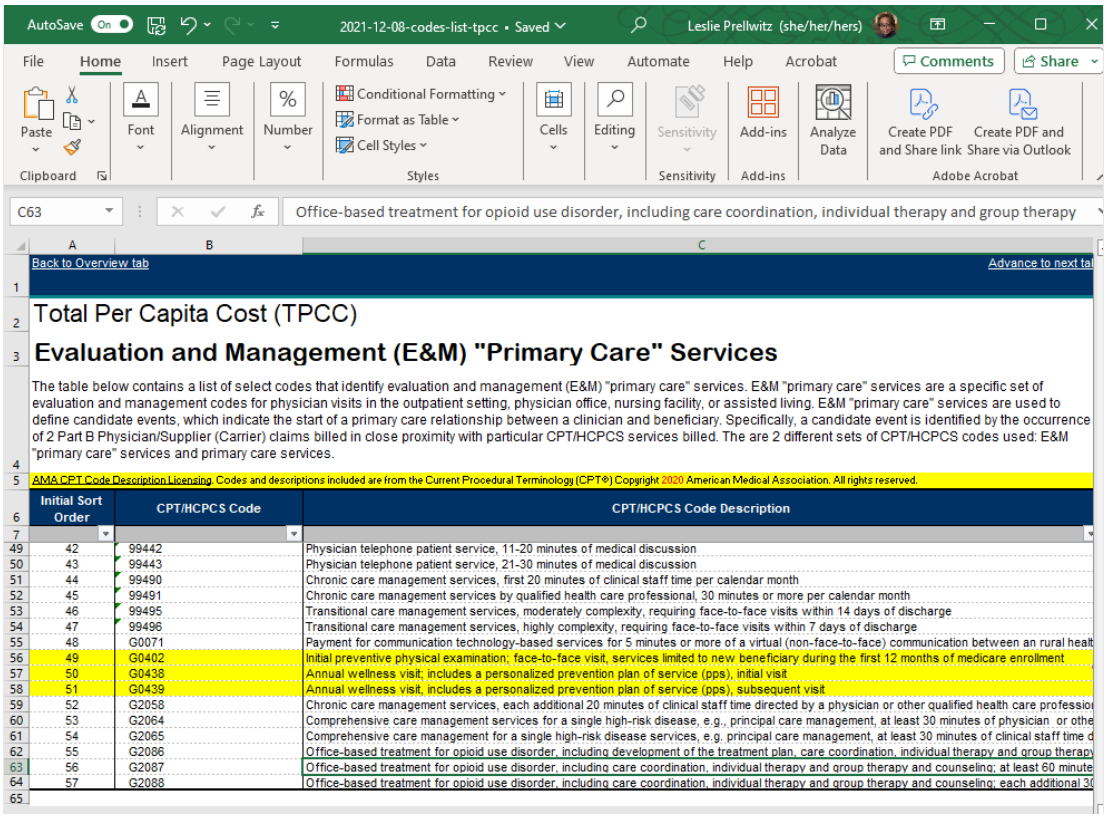
Initial Sort Order	CPT/HCPCS Code	CPT/HCPCS Code Description
1	99201	New patient office or other outpatient visit, typically 10 minutes
2	99202	New patient outpatient visit, total time 15-29 minutes
3	99203	New patient office or other outpatient visit, 30-44 minutes
4	99204	New patient office or other outpatient visit, 45-59 minutes
5	99205	New patient office or other outpatient visit, 60-74 minutes
6	99211	Office or other outpatient visit for the evaluation and management of established patient that may not require presence of healthcare professional
7	99212	Established patient office or other outpatient visit, 10-19 minutes
8	99213	Established patient office or other outpatient visit, 20-29 minutes
9	99214	Established patient office or other outpatient visit, 30-39 minutes
10	99215	Established patient office or other outpatient visit, 40-54 minutes
11	99304	Initial nursing facility visit per day, typically 25 minutes
12	99305	Initial nursing facility visit per day, typically 35 minutes
13	99306	Initial nursing facility visit per day, typically 45 minutes
14	99307	Follow-up nursing facility visit per day, typically 10 minutes
15	99308	Follow-up nursing facility visit per day, typically 15 minutes
16	99309	Follow-up nursing facility visit per day, typically 25 minutes
17	99310	Follow-up nursing facility visit per day, typically 35 minutes
18	99315	Nursing facility discharge day management, 30 minutes or less
19	99316	Nursing facility discharge management, more than 30 minutes
20	99318	Nursing facility annual assessment, typically 30 minutes
21	99324	New patient custodial care facility, group care, or assisted living visit, typically 20 minutes
22	99325	New patient custodial care facility, group care, or assisted living visit, typically 30 minutes
23	99326	New patient custodial care facility, group care, or assisted living visit, typically 45 minutes
24	99327	New patient custodial care facility, group care, or assisted living visit, typically 1 hour
25	99328	New patient custodial care facility, group care, or assisted living visit, typically 75 minutes

Seen in the screenshot above are the 2023 Performance Measure specification for Total Per Capita Cost measure.[3] AMA Copyright continues to indicate the year 2020. Codes not updated from 2022 metrics.

[3] 2023 E&M "Primary Care" Services List accessed on December 13, 2023 from https://qpp.cms.gov/mips/explore-measures?tab=costMeasures&py=2023.



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Total Per Capita Cost (TPCC)

Evaluation and Management (E&M) "Primary Care" Services

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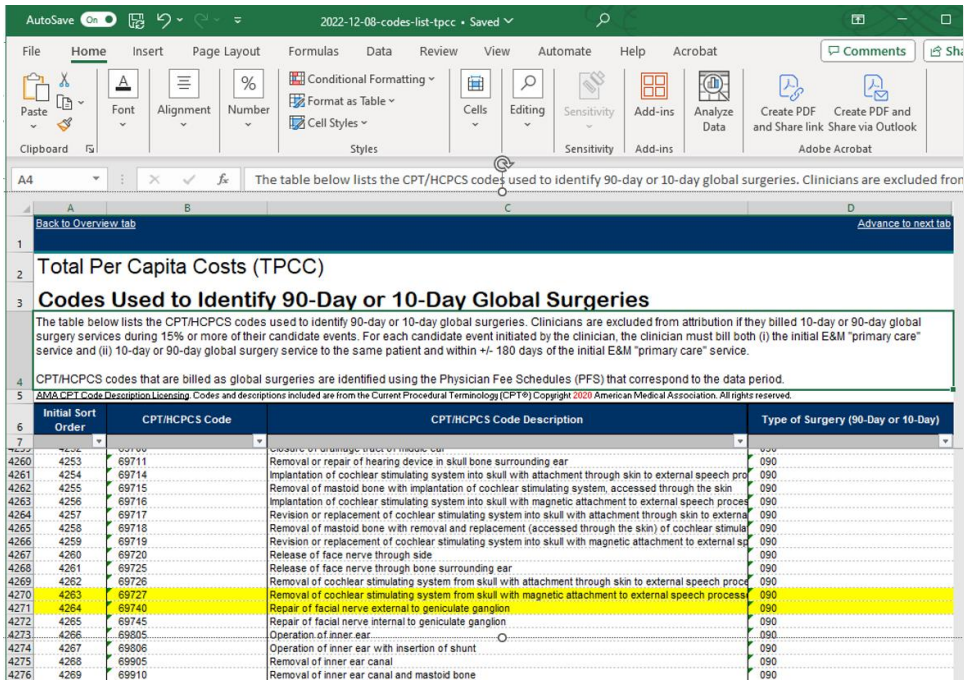
Initial Sort Order	CPT/HCPCS Code	CPT/HCPCS Code Description
42	99442	Physician telephone patient service, 11-20 minutes of medical discussion
43	99443	Physician telephone patient service, 21-30 minutes of medical discussion
44	99490	Chronic care management services, first 20 minutes of clinical staff time per calendar month
45	99491	Chronic care management services by qualified health care professional, 30 minutes or more per calendar month
46	99495	Transitional care management services, moderately complexity, requiring face-to-face visits within 14 days of discharge
47	99496	Transitional care management services, highly complexity, requiring face-to-face visits within 7 days of discharge
48	G0071	Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural healt
49	G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment
50	G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
51	G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit
52	G2058	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professio
53	G2064	Comprehensive care management services for a single high-risk disease, e.g., principal care management, at least 30 minutes of physician or othe
54	G2065	Comprehensive care management for a single high-risk disease services, e.g. principal care management, at least 30 minutes of clinical staff time d
55	G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy
56	G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minute
57	G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30

As seen in the screen shot above, there is an incomplete CPT metric selection, which is seen in the 2022 TPCC Codes list.[4] CMS G codes for Initial Preventive Physical Examination and wellness visit were included, but analogous codes from CPT for Preventive Medicine Services for new and established patients in the appropriate age ranges (CPT codes 99386, 99387, 99396 and 99397), all of which were established in 2009, were not included. Therefore, the underlying base patient population selected is incomplete.

[4] See supra at 2.



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Total Per Capita Costs (TPCC)

Codes Used to Identify 90-Day or 10-Day Global Surgeries

The table below lists the CPT/HCPCS codes used to identify 90-day or 10-day global surgeries. Clinicians are excluded from attribution if they billed 10-day or 90-day global surgery services during 15% or more of their candidate events. For each candidate event initiated by the clinician, the clinician must bill both (i) the initial E&M "primary care" service and (ii) 10-day or 90-day global surgery service to the same patient and within +/- 180 days of the initial E&M "primary care" service.

CPT/HCPCS codes that are billed as global surgeries are identified using the Physician Fee Schedules (PFS) that correspond to the data period.

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Initial Sort Order	CPT/HCPCS Code	CPT/HCPCS Code Description	Type of Surgery (90-Day or 10-Day)
4253	69711	Removal or repair of hearing device in skull bone surrounding ear	090
4254	69714	Implantation of cochlear stimulating system into skull with attachment through skin to external speech pro	090
4255	69715	Removal of mastoid bone with implantation of cochlear stimulating system, accessed through the skin	090
4256	69716	Implantation of cochlear stimulating system into skull with magnetic attachment to external speech proces	090
4257	69717	Revision or replacement of cochlear stimulating system into skull with attachment through skin to externa	090
4258	69718	Removal of mastoid bone with removal and replacement (accessed through the skin) of cochlear stimula	090
4259	69719	Revision or replacement of cochlear stimulating system into skull with magnetic attachment to external sp	090
4260	69720	Release of face nerve through side	090
4261	69725	Release of face nerve through bone surrounding ear	090
4262	69726	Removal of cochlear stimulating system from skull with attachment through skin to external speech proc	090
4263	69727	Removal of cochlear stimulating system from skull with magnetic attachment to external speech process	090
4264	69740	Repair of facial nerve external to geniculate ganglion	090
4265	69745	Repair of facial nerve internal to geniculate ganglion	090
4266	69805	Operation of inner ear	090
4267	69806	Operation of inner ear with insertion of shunt	090
4268	69905	Removal of inner ear canal	090
4269	69910	Removal of inner ear canal and mastoid bone	090

The above screen shot is from the 2023 Performance Measure specification for Total Per Capita Cost measure.[5] AMA Copyright continues to indicate 2020. Codes were not updated for measurement period.

CPT codes 69716, 69717, 69719, 69726, 69727, all codes pertaining to Osseointegrated Implants, with 90-day global periods and modified effective January 1, 2022, are not using accurate codes and descriptors. There is a disproportionate impact on the specialty of Otolaryngology Surgery with these omissions and lack of use of updated codes.

In addition, while the following example applies to the 2023 performance period, we believe it is important as it illustrates that using old code sets results in inaccurate and incomplete data and that the problems are poised to continue going forward. Specifically, the following CPT codes, effective January 1, 2023, with 90-day global period, are not included in the base data selection list:

- 69728 *Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex*
- 69729 *Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex*
- 69730, *Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex*

[5] 2023 HCPCS Surgery Tab accessed on December 13, 2023 from https://qpp.cms.gov/mips/explore-measures?tab=costMeasures&py=2023.

Appendix B

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid
Services 7500 Security
Boulevard, Mail Stop S3-02-01
Baltimore, Maryland 21244-1850

November 16, 2023

James L. Madara, MD
American Medical Association
330 N, Wabash Avenue
Suite 39300
Chicago, IL 60611-

Dear Dr. Madara:

Thank you for your letter to the Centers for Medicare & Medicaid Services (CMS) on behalf of the American Medical Association (AMA) requesting CMS:

- Extend the Targeted Review period.
- Allow physicians to claim Extreme and Uncontrollable Circumstances (EUC) during the requested extended Targeted Review period.
- Reweight the 2022 cost performance category or, if not feasible, zero out the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) Clinician from the 2022 performance year calculations.
- Study and re-evaluate the overall cost performance category and the associated measures.

CMS is committed to working with the AMA and appreciates your recommendations. We have reviewed each of your requests carefully and provided a detailed response below.

Extend the Targeted Review Period.

While we understand that some clinicians may not have been aware that they were required to participate in the Merit-based Incentives Payment System (MIPS), clinicians and their authorized representatives have had almost 4 months to review their MIPS performance feedback and contact CMS with questions. On June 15, 2023, we announced through the Quality Payment Program (QPP) listserv and on the QPP website that clinicians, groups, virtual groups and APM Entities had the ability to preview their 2022 MIPS final score and to contact the QPP Service Center with questions. On August 10, 2023, we announced that 2022 MIPS final scores and 2024 MIPS payment adjustments were available, and that the 2022 targeted review period was open. We also sent six reminder listservs to promote awareness. Additionally, if the targeted review period were extended

or left open until the end of this year, payment adjustments for all clinicians wouldn't be available by January 1, 2024. Therefore, we are unable to extend the targeted review period.

Allow physicians to claim Extreme and Uncontrollable Circumstances (EUC) during the requested extended Targeted Review period.

We do not have the authority to allow clinicians to request performance category reweighting due to an extreme and uncontrollable circumstance through the targeted review process. Targeted review offers the opportunity for clinicians to request that CMS re-evaluate their final score to ensure that their scores and associated payment adjustment(s) are in alignment with finalized policy. As noted in the 2022 Targeted Review User Guide, a clinician or group can request a targeted review if they qualified for performance category reweighting through an approved MIPS EUC Exception application, but that reweighting wasn't reflected in their final score. A clinician cannot initiate a new request for reweighting, citing an extreme and uncontrollable circumstance, through a targeted review.

As indicated in your letter, we reopened the EUC Exception Application for the 2020 performance period in the fall 2021. Due to technical limitations, we had to leverage the targeted review application for the submission of these new EUC reweighting requests. However, this type of flexibility was tied to, and in recognition of, the public health emergency declaration, which ended May 11, 2023.

Furthermore, we previously extended the EUC Exception application deadline for the 2022 performance period from January 3, 2023, to March 3, 2023, giving clinicians about ten months to submit an application if needed. This extension was announced through the QPP listserv on December 29, 2022, and noted in several reminder listservs through the deadline. This information was also added to a banner at the top of every page on the QPP website.

We appreciate the AMA's advocacy on behalf of clinicians. We welcome any suggestions you have to help improve education and outreach efforts so that clinicians and their staff receive important program information as effectively as possible.

Reweight the 2022 cost performance category or, if not feasible, zero out the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) Clinician from the 2022 performance year calculations.

We do not believe it would be appropriate to reweight the cost performance category to 0 percent or exclude the TPCC and MSPB Clinician measures from scoring for the 2022 MIPS performance year. This decision, as well as the process used to determine any cost performance category reweighting or cost measure scoring exclusions, is described in more detail in the 2022 MIPS Cost Measure Exclusion Fact Sheet. We have reviewed and responded to the AMA's comments below as further explanation on why the cost performance category, MSPB Clinician, and TPCC will be included in MIPS scoring for the 2022 performance period.

Current Procedural Terminology (CPT) Codes in MSPB Clinician and TPCC Specifications

We appreciate the AMA's feedback about aligning the MSPB Clinician and TPCC measure specifications with updated CPT codes. We would like to clarify that all MIPS cost measures, including TPCC and MSPB Clinician, undergo annual maintenance. The Measure Codes Lists that detail the specific codes used to construct the measures are also updated annually and made publicly available on the QPP website for any interested parties to review. As part of the annual maintenance process, the measure developer added new Evaluation and Management (E&M) and other CPT codes to the measure specifications when the new codes aligned with the original intent of the measure and did not constitute a substantive change.

In addition to considering newly added CPT codes, the measure developer monitors for CPT codes that are revised or deleted. For revised codes, the measure developer considers whether the changes necessitate updates to the measure specifications. Changes to billing guidance and code descriptions that do not alter the clinical relevance of the services to the measure do not require updates to the specifications. Regarding deleted codes, certain deleted CPT/HCPCS codes are intentionally retained in the specifications for a period of time after deletion. The services represented by these codes have been determined to be clinically appropriate to include during measure development and finalization for use in MIPS, and there is no evidence that these codes no longer fit within the intent of the measures.

Furthermore, the codes continue to be used by some clinicians and these can represent important services and evidence of care relationships. The measure developer conducted an analysis demonstrating that a CPT code deleted in the 2021 codebook was still being billed in a significant manner in 2021 and 2022. At this time, there is no evidence that their continued inclusion impacts the reliability or validity of the measure or how the measure score is calculated; however, there is evidence to suggest that removing these codes could fail to capture applicable episodes.

Attribution of Cost Measures to Qualified Health Professionals (QHPs) and Other Specialists

We continue to believe that the cost measures are attributing costs to clinicians and groups as specified. We understand the AMA has raised concerns regarding clinician and group attribution of certain cost measures, including TPCC, MSPB Clinician, and the Diabetes episode-based cost measure, and whether these measures appropriately assess specialist performance.

Due to the nature of the MIPS group reporting, it is expected that some specialists may be scored on the episode-based cost measures even if the clinician is not individually attributed episodes for those measures. Clinicians may be participating in MIPS as part of a group practice that has attributed sufficient episodes under those measures to meet the established case minimum. If a clinician participates in MIPS as part of a large group practice that provides a variety of care, it is reasonable that they may be attributed a measure assessing costs of services that they did not provide but that someone else from their group did provide.

This is similar to group reporting for quality measures, where a clinician may be scored for a quality measure that is outside the specific care they provide.

Diabetes Episode-Based Cost Measure Attribution to Ophthalmologists

Using the example of the Diabetes episode-based cost measure, the Diabetes episode-based cost

measure intends to assess ongoing treatment and management of diabetes and to attribute episodes to the clinicians and group practices providing such care. The Diabetes clinician expert workgroup developed a list of clinically related services and diagnoses indicative of care relationships for managing diabetes (e.g., evaluation and management services paired with a diabetes diagnosis), which CMS uses to identify and attribute episodes. A Diabetes episode is attributed to group practices providing 2 clinically related services to a patient within 180 days. Clinicians are attributed the episode if they are part of the attributed group practice and provide 30% or more of the clinically related services used for attribution within that episode. Moreover, clinicians and group practices must meet the 20-episode case minimum to be scored on the Diabetes measure.

CMS acknowledges that medications are essential to diabetes treatment and management. Based on feedback from the clinician expert workgroup and other interested parties, the Diabetes episode-based cost measure includes an additional check for clinician attribution. A clinician must have prescribed at least 2 condition-related medications to 2 patients during the current plus prior performance period to be attributed a Diabetes episode. As such, clinicians who do not serve as prescribers of these drugs for patients with diabetes will not be attributed.

This clinician-level check was part of the specifications reviewed through the pre-rulemaking process and the Calendar Year 2022 Medicare Physician Fee Schedule rulemaking process. Therefore, it was in effect for the 2022 performance period. Furthermore, measures are reviewed and updated with non-substantive changes as part of the annual maintenance process. Through this process, we are adding a group-level medication attribution check for the 2023 performance period.

Starting in 2023, for a group practice to be attributed Diabetes episodes, at least one clinician within the group practice must have prescribed at least 2 condition-related medications to 2 patients within the current plus prior performance period, which parallels the current clinician- level check.

TPCC Attribution to Qualified Health Professionals (QHPs)

We understand the AMA has received reports of QHPs (e.g., nurse practitioners and physician assistants) being scored on the TPCC measure due to inpatient billing. The TPCC measure is attributed to clinicians using E&M "primary care" services, which are a specific set of evaluation and management codes for visits in the outpatient, office, nursing facility, or assisted living settings. While clinicians who practice in an inpatient setting may be scored on the TPCC measure, these clinicians and their groups are attributed TPCC candidate events based on non-inpatient E&M "primary care" services.

Specialist Performance on Population-Based Cost Measures

The AMA raised concerns on whether population-based cost measures—MSPB Clinician and TPCC—appropriately assess cost performance for specialists (i.e., oncologists, rheumatologists). One concern is that rheumatologists may be performing poorly on the TPPC measure and that this is due to high-cost Part B drugs. We note that the TPCC measure includes a specialty adjustment to account for the fact that costs vary across specialties and clinician groups with varying specialty compositions. In addition to the specialty adjustment, the TPCC measure includes risk adjustment to account for comorbidities and other patient-level factors that could influence the use of high-cost Part B drugs.

The AMA also shared a recent study published in *JCO Oncology Practice*; the study's authors concluded that oncologists scored poorly on population-based cost measures relative to other specialties. CMS has previously reviewed the referenced study and related publications and determined that the evidence does not support a need to alter the MSPB Clinician or TPCC measures, nor to change how oncologists are scored on these measures. We came to these conclusions based on the following:

1) The study uses 2018 data, which does not reflect the current MSPB Clinician nor TPCC measure. Both the MSPB Clinician and TPCC measures underwent substantial revisions as part of a prior comprehensive re-evaluation, with the revised measures being implemented for MIPS starting in 2020. As such, it is not appropriate to draw conclusions about the current MSPB Clinician and TPCC measures based on data from before 2020.

2) The MSPB Clinician and TPCC measures are not agnostic to clinician specialty, types of care provided, or patient-level risk factors that can influence costs of care. Both measures use various adjustments and exclusions to account for expected cost differences.

3) Third, as noted above, MIPS scoring policies are designed such that clinicians' scores may reflect cost measures beyond their direct scope of practice. For example, an oncologist may be scored on cost measures as part of a group practice, which could include care that is not limited to oncology.

Variation in Performance on Cost Measures

The AMA noted an example of an internal medicine clinician who reportedly performed very poorly on the Asthma/COPD cost measure despite performing well on the TPCC cost measure. It is expected that clinicians may have varied performance across multiple measures, as the type of care being assessed in the measure is intended to be different. TPCC assesses all costs related to primary care, whereas the Asthma/COPD measure assesses care specifically related to the ongoing care management of patients with chronic Asthma or COPD. It is reasonable that clinicians may have different scores depending on which aspects of care are assessed under a given measure.

Study and re-evaluate the overall cost performance category and the associated measures.

We acknowledge the AMA's recommendation to study and re-evaluate cost measures. CMS and the measure developer are committed to ongoing monitoring and maintenance of MIPS cost measures. Most recently, the measure developer initiated a comprehensive re-evaluation of TPCC, MSPB Clinician, and 8 episode-based cost measures which were implemented in MIPS starting with the 2020 performance period. As these measures have been in MIPS for 3 years, the measure developer is conducting a holistic review of the measure specifications, including information gathering, empirical analyses, seeking input from interested parties through public comment periods, and convening Technical Expert Panels (TEP) and other expert workgroups, as appropriate. The developer hosted a public comment period in summer 2023 and convened the standing project TEP to review TPCC in September 2023. The comprehensive re-evaluation process is ongoing. Additionally, CMS and the measure developer will continue to analyze whether the cost performance category and MIPS cost measures are assessing clinician cost performance as intended.

Thank you for your feedback on behalf of AMA's membership. We sincerely appreciate your interest in these important issues as we work toward the shared goal of strengthening the Quality Payment Program

and improving patient care.

Sincerely,

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