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October 27, 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 take immediate action to address serious, unintended problems with the Merit-based Incentive Payment System (MIPS) Cost Performance Category. **Specifically, we urge CMS to 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, on top of a 3.36 percent reduction to the conversion factor. CMS should also study and re-evaluate the Cost Performance Category and all administrative claims measures.**

In 2022, the Cost Performance Category accounted for 30 percent of eligible professionals' MIPS final scores and significantly contributed to physicians' 2024 MIPS payment adjustments, which have the potential to cut their Medicare payment by up to -9 percent. Yet, physicians had no way to anticipate, monitor, and improve their Cost Performance Category score because CMS did not share any data about their attributed measures, their attributed patients, and their observed costs until August 2023 – more than eight months after the conclusion of the performance period. Prior to August 2023, there has been no information about this category since 2020 based on 2019 performance when only a few episode-based cost measures (EBCMs) and the now-retired versions of the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) were in use.

We must agree that the goal of administrative claims cost and quality measures is to help physicians to improve by reducing unnecessary costs and utilization and that timely, actionable data about the measure methodologies is essential to assist physicians in improving. Congress recognized the importance of data sharing in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Under MACRA, 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).[1]

[1] §42 USC 1395w-4(q)(12).

Despite this requirement, physicians did not receive their most recent MIPS Feedback Report based on 2022 performance from CMS until August 2023. These reports and other publicly available MIPS data are replete with errors and shortcomings, as detailed in a recent AMA letter. Furthermore, 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. Without this information on a real-time or even quarterly basis, it is impossible for physicians to implement changes that would improve patient care, outcomes, and use resources more efficiently, saving costs to the Medicare program. By failing to share timely data, CMS is subverting the goal of the cost measures and instead seeding distrust in the measures and CMS' objective with the MIPS Cost Performance Category. Are the cost measures meant to reduce unnecessary costs for Medicare beneficiaries and for the Medicare program or are they simply meant to penalize physicians?

Turning to the 2022 cost measures, we are concerned that CMS did not use the most updated Current Procedural Terminology (CPT®) codes for its TPCC and MSPB measure specifications in 2022 and 2023. We believe this may further exasperate the number of physicians who receive penalties in 2024. As highlighted in our 2024 Medicare Physician Payment Schedule (MFS) proposed rule comments, the AMA reviewed the coding specifications currently posted to the Quality Payment Program website for 2023 and found that the coding specifications for the TPCC and MSPB have not been updated since 2020. The Evaluation & Management (E/M) section of the CPT code set underwent a major update in 2021, resulting in significant changes to the Office & Other Outpatient visit codes. In 2023, other code ranges were updated as well, including the Inpatient & Observation codes, Nursing Facility codes, and Emergency Medicine codes to name a few. These changes are on top of the usual yearly addition/revision/deletion of codes throughout the set. The CMS MIPS CPT coding specifications for TPCC and MSPB do not align with the CPT codes for the 2022 performance period or the current year (2023).

Additionally, our recent review of the CPT codes in the Surgical Attribution tab of the MSBP measure identified potential flaws in the coding for the surgical attribution methodology. For example, for a patient admitted to the hospital under the surgical diagnosis-related group (DRG) 040 (Peripheral/Cranial Nerve & Other Nervous System Procedures), it would be expected that a specific neurological procedure as listed in the Medicare Severity-Diagnosis Related Group (MS-DRG) specification was performed. However, in the CPT code mapping, there are many CPT procedure codes listed, such as CPT code 49561 (*Repair of trapped incisional or abdominal hernia*), that do not correspond to the principal procedures that are associated with the MS-DRG specified. In the case of MS-DRG 040, principal procedures would relate to operating room procedures such as nerve excisions, divisions, extirpations of matter, extractions, releases, and repairs. Selecting inpatient encounters based on the criteria as currently represented would not yield a sensible set of encounters suitable for quality comparisons.

Furthermore, while the AMA's understanding of how the 2022 cost measures worked in the real world is hamstrung by the lack of publicly available data from CMS, we have heard multiple accounts of unintended negative consequences and have serious concerns that the cost measures are not operating as intended during their development. We are concerned by reports that group practices are being measured on the TPCC measure despite being excluded from the measure due to Qualified Health Professionals (QHPs) in their group practice billing Medicare directly. Similarly, we heard from hospital based QHPs that they were scored on TPCC despite the inpatient E/M codes being excluded from the measure specifications. We have heard from an internal medicine physician who scored very poorly on the Asthma/COPD cost measure despite performing well on the TPCC measure. It appears that one of the 20 patients attributed to the Asthma/COPD measure had sepsis during the performance period, which had an outsized impact on the physician's score. Additionally, we heard from a large multi-specialty practice that

they scored poorly on the joint replacement EBCMs, despite being high performers in the Center for Medicare Innovation's Bundled Payments for Care Improvement Advanced alternative payment model.

We have also heard that rheumatology practices are performing poorly on the TPCC measure, likely due to high Part B drug costs. As flagged in our 2024 MFS comment letter, a recent study[2] published in *JCO Oncology Practice* found that oncologists scored poorly on cost measures compared with other specialties in 2018 when the Cost Performance Category made up a relatively small portion of the overall MIPS score. Based on this study and what we are hearing from physicians, the AMA is concerned that neither the TPCC nor the MSPB measures fully account for the variation in costs in the standard-of-care medicine by specialty and that CMS is conducting an apples-to-oranges comparison.

We have further concerns about the attribution methodology of the chronic condition EBCMs. We are hearing that these measures are misattributing these costs to physicians who are not managing these conditions. For example, we heard from an interventional cardiologist who was attributed the diabetes EBCM. Similarly, we have heard that numerous ophthalmologists are being inappropriately attributed the diabetes EBCM because they treat co-morbidities of diabetes, such as diabetic eye disease, and not the patient's underlying diabetic disease. To ensure against this, CMS implemented a check on attribution but only at the individual level and did not apply it to the group level. We were pleased that CMS agreed to fix this error for 2023 and beyond but are extremely disappointed that CMS has indicated it will not fix this problem for the 2022 performance period.

When taken together, these problems raise serious doubts about whether the MIPS cost measures are fairly and accurately assessing variations in costs within the control of MIPS eligible clinicians as intended. We recommend that CMS study and re-evaluate the overall Cost category and the associated measures because it appears that the measures and underlying methodologies are resulting in major unintended consequences that will negatively impact physicians' payment for services provided to Medicare beneficiaries next year and not working as envisioned by Congress. **We strongly urge the agency to reweight this category to zero and correct these problems before they negatively impact payment and patient access to care.**

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 202-789-7409 or margaret.garikes@ama-assn.org with any questions or to discuss further.

Sincerely,

James L. Madara, MD

[2] DOI: 10.1200/OP.22.00858 *JCO Oncology Practice* 19, no. 7 (July 01, 2023) 473-483.