March 2, 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

Dear Administrator Brooks-LaSure:

On behalf of the undersigned organizations representing physicians across the country, we agree with the Centers for Medicare & Medicaid Services' (CMS) aims in the Merit-based Incentive Payment System (MIPS) Value Pathway (MVP) to reduce burden and meaningfully align quality, cost, health information technology, and improvement metrics for physicians and their patients as both are consistent with congressional intent in the Medicare Access and CHIP Reauthorization Act (MACRA). We greatly appreciate the ongoing dialogue between CMS and our organizations to develop MVPs that achieve these aims, as well as the newly established public comment period to review and offer recommendations about draft MVPs. While MVPs as currently implemented are a step in the right direction, we believe there are opportunities to improve and offer recommendations for your consideration ahead of calendar year 2024 Medicare Physician Payment Schedule rulemaking.

<u>To Get to Value, Look to Alternative Payment Models (APMs), Not MIPS, As a Guidepost</u>

CMS should propose a pathway for advancing MVPs away from the siloed reporting requirements and complex scoring methodology of MIPS to align with APMs. We appreciate that CMS acknowledges one of the goals of MVPs is to give physicians an opportunity to gain familiarity with value-based care arrangements. We recommend that CMS provide more options aimed at physicians who choose to have their MIPS participation more aligned with an APM, including:

- Holding physicians accountable for aligned quality and cost measures tied to a clinical condition, episode of care, or public health priority.
- Scoring the Promoting Interoperability (PI) performance category based on physicians either attesting that they (or at least 75 percent of the eligible clinicians in their group) are using certified electronic health record technology (CEHRT) or health information technology (health IT) that interacts with CEHRT, or alternatively this attestation would be made automatically by the act of submitting their quality data electronically using a qualified clinical data registry (QCDR).
- Awarding physicians automatic full credit in the Improvement Activity (IA) category similar to MIPS APMs, as well as recognized patient-centered medical homes.

We appreciate CMS' focus on engaging more non-primary-care specialists in APMs and believe MVPs could play an important role in facilitating this uptake, particularly in conjunction with a sustainable subgroup reporting option. Finally, we note that CMS often cites limited statutory authority, but the agency has used its existing authority to define the MIPS APM participation option, which is not referenced in the statute, to better reconcile the differences between MIPS and APMs. For example, MIPS APMs are not scored on the Cost Performance Category to allow MIPS APM participants to focus on one

set of cost measures in the APM. CMS should extend its authority for MIPS APMs policies to MVPs, wherever possible, so MVPs would be better positioned as a stepping stone between MIPS and APMs.

Propose Meaningful Reductions in Burden for MVP Participants

Changes in MIPS requirements add to the administrative burdens of the program. Although one goal of MVPs is to reduce burden, the changes finalized to date (e.g., reporting as few as four rather than six quality measures) are modest and may not offset the added burdens of reporting MVPs, such as forming a new subgroup. In addition, CMS has added population health quality measures as a foundational requirement on top of the general quality measure requirements. While measuring improvement on population health is important, introducing additional, one-size-fits-all requirements rather than incorporating them into existing criteria and tailoring them to the MVP adds unnecessary complexity. We offer the following additional recommendations to further reduce burden for MVP reporters:

- Increase scoring simplicity and predictability by not imposing additional restrictions, such as requiring reporting on a certain minimum number of measures, type or focus of measures, or by assigning varying measure weights.
- Incentivize cross-category actions through multi-category scoring. For example, MVP participants could receive automatic credit for the IA Category for reporting population health or beneficiary engagement quality measures via a QCDR.
- CMS should take full advantage of the flexibility to demonstrate use of CEHRT (e.g., straightforward yes/no attestation) found in The Health Information Technology for Economic and Clinical Health Act. Especially considering CMS' National Quality Strategy goal of transitioning to digital quality measures by 2030. Adoption of digital quality measures (dQM) makes the PI category obsolete since the technology standards are inherently built into quality measure specifications and the use of health IT in an interoperable fashion will be necessary to enable dQMs.

Prioritize MVPs by Condition, Episode of Care and Clinical Priority Areas, Not Just by Specialty

We believe quality measures should help inform patients about where to find the care that meets their expectations, incentivize care teams to partner with patients to achieve patient goals, and help inform care teams about areas in need of improvement. While MVPs as currently implemented are a step in the right direction, MVPs fall short of these criteria. We understand CMS' concern that a proliferation of MVPs could introduce added complexity, thereby undermining their original purpose. However, this concern should not lead CMS to limit MVPs to overly broad specialty measure sets that, in some cases, would compare physicians in the same specialty but that have differing sub-specializations and/or varying practice arrangements against one another. The proposed MVP *Focusing on Women's Health* has raised some concerns and questions regarding its consistency with MVP Guiding Principles and intent. We believe the MVP as written does not adhere to many of these Guiding Principles including its failure to distinguish between the maternity care population and the gynecologic population encompassed within the proposed MVP. These measures are not "limited, connected, or complementary" as emphasized by the current MVP Guiding Principles. The intention of the MVP is muddied by including measures across these distinct populations without consideration of how these two populations are treated in practice. A refined MVP more focused on gynecology and women's health prevention and wellness with a new MVP focused on maternity care is more in line with these guiding principles and the intent of MVPs as expressed by CMS, as well as the Administrations goals on improving maternal health. The same holds true for the proposed *Quality Care in Mental Health and Substance Use Disorders* MVP.

As currently drafted, the majority of finalized and proposed MVPs repeat many of the problems with traditional MIPS—notably a lack of clinical relevance to physicians and the way they practice, as well as individualized patient needs. For instance, orthopaedic and neurosurgeons who specialize in spine surgery appear to fall under the *Musculoskeletal Care and Rehabilitative Support* MVP, but the functional status measures capture rehab/therapy/chiropractic services and not surgery. Therefore, the MVP has little to no relevancy for surgeons or patients for deciphering physician outcomes when deciding to have spine surgery. Additionally, the *Promoting Wellness* MVP should promote investing in preventive services as a critical element of the transformation to value-based health care, but because this MVP includes the total per capita cost measure, physicians could be unfairly penalized for successfully improving the utilization of recommended preventive services while total costs are measured in the same year as those services are provided. While higher utilization of preventive services may reduce costs in the long-term, this MVP is not currently designed to capture those savings and does not account for the value of those services. By contrast, CMS established the *Improving Care for Lower Extremity Joint Repair* MVP, which includes quality and cost measures that evaluate care for patients needing lower extremity surgical repair, such as fractures and total joint replacements. Unlike a broad MVP that would include orthopaedic surgeries from multiple, significantly different anatomic regions, this MVP has the potential to provide physicians with actionable performance feedback about patient outcomes and avoidable costs, as well as useful information to patients who may be able to shop around for this surgery. With this MVP as a precedent, CMS should work with national medical specialty societies to develop MVPs around targeted episodes of care or conditions and with appropriate measures, rather than developing MVPs at the broad specialty level and simply repackaging problematic measures. MVPs should move us closer towards patient-centered care, not further from it.

Accordingly, we strongly urge CMS to work closely with the national medical specialty societies to develop an MVP prioritization framework and work with the specialty societies to develop MVPs that address priority areas, such as substance use disorder, maternal health, care coordination and integration between primary care physicians and non-primary care specialists, home-based care options for patients with chronic conditions. We also believe that providing more timely data in both traditional MIPS and MVP will enable CMS and specialty societies to develop new MVPs based on valid, reliable MIPS and QCDR measures, identify promising new measure concepts, and agree on additional high-priority clinical areas and patient populations to target to reduce avoidable costs and improve quality.

<u>Ensure MVPs Remain Voluntary</u>

We strongly oppose retiring traditional MIPS and making MVP participation mandatory. CMS must recognize that there may not be a viable APM for every specialty to participate in and, therefore, we believe it is important to retain traditional MIPS as an option for those clinicians.

Thank you for your attention to these recommendations. We welcome the opportunity to continue working with CMS to identify opportunities to improve quality, patient outcomes, and efficiencies in the Medicare program via MVPs.

Sincerely,

American Medical Association
AMDA - The Society for Post-Acute and Long-Term Care Medicine
American Academy of Dermatology Association

American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopedic Surgeons
American Academy of Otolaryngic Allergy
American Association of Neurological Surgeons
American College of Allergy, Asthma & Immunology
American College of Cardiology
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American College of Osteopathic Internists
American College of Physicians
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society of Cataract and Refractive Surgery
American Society of Retina Specialists
American Academy of Ophthalmology
Association for Clinical Oncology
Association of American Medical Colleges
College of American Pathologists
Congress of Neurological Surgeons.
Medical Group Management Association
Renal Physicians Association
Society for Vascular Surgery
Society of Hospital Medicine
Society of Interventional Radiology
Society of Nuclear Medicine and Molecular Imaging
The Society of Thoracic Surgeons