AMA
AMERICAN MEDICAL ASSOCIATION

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September 28, 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: 2022 MIPS Performance Period / 2024 MIPS Payment Adjustments

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 ensure physicians do not receive a Merit-Based Incentive Payment System (MIPS) penalty in 2024 that could reach up to nine percent, on top of the 3.36 percent conversion factor reduction. On August 10, 2023, CMS made available MIPS Performance Feedback for the 2022 performance year, which determines whether physicians will receive a positive, neutral, or negative payment adjustment on Medicare services furnished in 2024. The AMA has heard alarming reports of physicians facing MIPS penalties in 2024 for the first time since the program started.

The MIPS program was largely paused for the 2019, 2020, and 2021 performance periods due to the COVID-19 Public Health Emergency (PHE), and, although we publicized this information, we have serious concerns that many practices were not aware that automatic COVID-19 flexibilities expired in 2022. As a result, practices may be unfairly penalized—particularly small, independent, and rural practices—due to their lack of awareness. We are also hearing from practices that were historically successful in the program and are now expected to receive a negative payment adjustment in 2024 due to the MIPS Cost category being calculated and increases to the performance threshold. Physicians had no way to anticipate 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 and the now-retired versions of the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) were in use.

At a minimum, we request that CMS extend the Targeted Review deadline for as long as possible, preferably until the end of 2023, and clarify that physicians can claim Extreme and Uncontrollable Circumstances (EUC) due to COVID-19 PHE as part of the Targeted Review request to recalculate their score. The Targeted Review deadline is scheduled to close on October 9, 2023.

The Omicron wave was at its peak in January and February of 2022. Staffing shortages were prevalent, inflation was at historical highs, and both trends continued throughout the year. Even if physician practices had sufficient staff to help with data submission, they may not have known that they had to submit a separate EUC application. There is CMS precedent to utilize the Targeted Review process to claim EUC due to the 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.

We also want to highlight that the 2022 MIPS Targeted Review Guide states that EUC is a justifiable circumstance for recalculation, but we are hesitant to disseminate this information widely without more clarification from CMS, since the agency only allows physicians and practices to request a Targeted Review once. As stated in the guide, a circumstance where you can request a targeted review is when "**You qualified for performance category reweighting because of a special status designation, Promoting Interoperability Hardship Exception, or Extreme and Uncontrollable Circumstances Exception that was incorrectly applied."**[1]

We are also concerned that CMS did not use the most updated Current Procedural Terminology® (CPT®) codes for its TPC and MSPB measure specifications in 2022 and 2023. We believe this will further exacerbate the number of physicians who receive penalties. Consequently, **we request that CMS zero out Cost for 2022 and 2023, like it did in 2020 and 2021. Alternatively, we urge CMS to allow practices to request that their Cost category be reweighted due to the EUC and out of date measure specifications for TPCC and MSPB.**

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 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, the AMA is hearing reports that the cost measures are not functioning as intended. We are concerned by reports that group practices are being measured on the TPCC measure despite being

[1] 2022 Targeted Review User Guide. Page 8.

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. Ophthalmologists are being scored on the Diabetes cost measure despite not managing their patients' diabetes or prescribing the medications necessary to control the condition. We have 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.

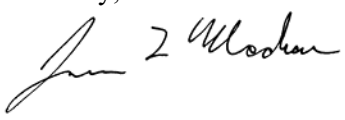
When taken together, these reports raise serious doubts about whether the MIPS cost measures are fairly and accurately assessing variations in costs within the control of MIPS eligible clinicians as intended. We recommend that CMS study and re-evaluate the overall Cost category and the associated measures 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 and correct these problems before they negatively impact payment and patient access to care.**

Therefore, we request the following in priority order to better ensure physicians are not faced with unprecedented payment adjustments in 2024:

1. Extend the Targeted Review period.
2. Allow physicians to claim EUC during the extended Targeted Review period.
3. Reweight 2022 Cost Category. If not feasible, zero out TPCC and MSPB from 2022 calculations.
4. CMS study and re-evaluate the overall Cost category and the associated measures.

Thank you for considering our request and taking the necessary steps to better ensure physicians are not unfairly penalized. 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,



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