AMA
AMERICAN MEDICAL ASSOCIATION

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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 physician and medical student members of the American Medical Association (AMA), I write to provide input to the Centers for Medicare & Medicaid Services (CMS) as it reevaluates the Total Per Capita Cost (TPCC) measure included in the Merit-based Incentive Payment System (MIPS) and considers other topics discussed during the March 2024 Physician Cost Measures and Patient Relationship Codes Technical Expert Panel (TEP) meeting. In addition, the AMA reiterates our urgent call for more timely and actionable feedback about the MIPS cost measures, including but not limited to TPCC.

Total Per Capita Cost Re-Evaluation

The current version of TPCC is fundamentally flawed because it attempts to hold physicians accountable for costs associated with medical conditions that the physician did not treat, medical decisions made by another provider, or care that the physician was not involved in. It also includes aspects and types of costs they cannot influence, such as changes in the prices of drugs, or coverage decisions for high priced drugs (e.g., GLP-1s). Furthermore, because the TPCC measure includes all Medicare Part A and B spending, not just the portions of spending that physicians can control, the TPCC measure provides physicians little or no actionable information about how to lower their spending, and it gives patients no useful information about how to lower their out-of-pocket costs or how to select physicians. TPCC does not enable physicians to determine whether they are making referrals to other physicians who order unnecessary tests or procedures or whose treatments result in avoidable complications and adverse events. Nor does the TPCC help a patient determine whether a particular physician will treat that patient's specific health problems more cost-effectively than another physician would. **Because of these fundamental flaws, the AMA strongly urges CMS to remove TPCC from MIPS or, at a minimum, remove it from any MIPS Value Pathway (MVP) in which there is an episode-based cost measure.**

If the TPCC continues to be used, it must be revised so that it is either limited to or focused on the aspects of cost that physicians can reasonably control and so that it avoids creating any incentive for physicians to undertreat patients. We recommend two changes in the TPCC:

1. Excluding all preventive services from the cost calculations, to avoid penalizing primary care physicians for the costs of these services, and

2. Grouping the services and costs in the measure into patient condition categories (e.g., separately calculating the costs of services for cardiovascular conditions, services related to cancer, musculoskeletal care services, trauma care services, etc.), so that it is clear which aspects of costs are more likely to be controlled or influenced by primary care services or by specific types of specialists.

The rationale for the first change is that TPCC currently penalizes physicians for delivering services designed to prevent health problems or treat them at early stages, because it counts the costs of those services but does not account for the savings that will accrue in the future by preventing health problems from occurring or avoiding the higher costs associated with treating more advanced illnesses. For example, patients who enroll in a diabetes prevention program will have higher costs in the performance period but will have lower costs in future periods if they avoid or delay the onset of Type 2 diabetes. Thus, TPCC penalizes physicians for taking actions today that will reduce future spending in the Medicare program. By contrast, in the Maryland Total Cost of Care Model, the Center for Medicare & Medicaid Innovation provides credit in its total cost of care calculations for the estimated future savings from reducing diabetes incidence. It would serve CMS well if its measure development contractor, Acumen, LLC, would develop a method for crediting future cost savings in TPCC. In the short term, the most feasible remedy would be to simply remove preventive services from TPCC.

The rationale for the second change is that the specialty adjustment in TPCC assumes that differences in total cost are based on differences in the specialty of the physician who is providing primary care services rather than differences in the types of treatments the patient needed during the year for their specific health problems. Moreover, the risk adjustment methodology is based only on chronic conditions in a prior year and does not consider current acute conditions or newly diagnosed chronic conditions that are treated for the first time during the current year. For example, a primary care physician who has a higher-than-average number of patients diagnosed with cancer during the year, particularly expensive-to-treat cancers, will be penalized by the TPCC because neither the risk adjustment methodology nor the specialty adjustment addresses this. However, by calculating costs related to cancer as a separate subcategory within TPCC, it would be clear whether the primary care physician's total cost per patient was higher due to those costs, or because that physician provides more services or more expensive services for the health conditions they manage directly. Similar changes are needed for specialty practices providing "primary care" services; for example, when an oncology practice is attributed a patient under TPCC, it could also be penalized under the current methodology, as research has shown.

In addition, the AMA continues to be extremely concerned with the shift to monthly benchmarking to evaluate a physician's performance on TPCC. We are particularly concerned that this change compromises the validity of the measure. For example, we do not believe CMS has adequately tested a monthly risk adjustment methodology, nor do we believe that a monthly cost assessment meets face validity. Has CMS examined the impact of this shift on the overall variation of the costs and to what extent those differences are due to scenarios such as a new versus established patient in the practice or seasonality of patient visits (e.g., winter flu cases or snowbirds)? In addition, spending for certain chronic conditions may be distributed over several months while spending for acute conditions will be concentrated in one month. Will physicians who see patients with multiple chronic conditions be fairly and accurately measured against physicians who see patients for acute conditions and vice versa? Further, we are concerned that a physician who is attributed six months of care could be disadvantaged compared to a physician who is able to spread the cost of care across all twelve months. **Because of these outstanding concerns, the AMA recommends that TPCC shift back to an annual, rather than monthly, evaluation of costs.**

Adjusting Attribution Rules

The AMA is pleased that CMS and its contractor, Acumen, LLC, are taking steps to address the current problem of attribution to a group practice that exclusively provides specialty care based on billing by nurse practitioners, physician assistants, and clinical nurse specialists within the group practice. We have previously written to CMS expressing our concerns that TPCC was inappropriately attributed to radiologists and hospitalists due to this problem. The AMA is supportive of the proposed refinement discussed by the Physician Cost Measures and Patient Relationship Codes TEP at the meeting on March 13, 2024, which would exclude qualified health professionals (QHPs) in group practices composed of only QHPs and excluded specialists. **CMS should implement this change as soon as feasible and apply the change retroactively to limit any unfair Medicare penalties that result from the current flawed attribution methodology.** It is essential that CMS apply this refinement to the 2023 MIPS performance period to mitigate unwarranted penalties to non-primary care specialists beginning in 2025.

However, CMS must do more to correct the problem of inaccurate attribution due to billing by QHPs, and it must also address other serious attribution problems that were not discussed at the March 2024 TEP meeting. Because the proposed refinement would only prevent inappropriate attribution to QHPs who are part of group practices that consist solely of excluded specialties, it would do nothing to prevent inappropriate attribution to groups that have both included and excluded specialties. This is an even larger group than the group that CMS would exclude under this refinement. Specifically, there are 6,559 groups (as identified by their tax identification number [TIN]) comprised of QHPs and excluded specialties, which accounts for about ten percent of TINs. However, there are 9,032 groups comprised of QHPs in groups with included and excluded specialties, and this accounts for about 14 percent of TINs. In multi-specialty groups that include both primary care physicians and non-primary care specialists, some or all of the QHPs could be supporting the work of the excluded specialists, yet patients could be attributed to the group solely because of the non-primary care services provided by the QHPs. This would also be inappropriate, and **CMS should identify the types and mixes of services that individual QHPs provide to develop additional ways to eliminate as many inappropriate attributions as possible.**

Refinements to the attribution process related to QHPs are important and desirable, but they do not address the other serious problems with TPCC attribution. Physicians would still have no way to indicate that they are the primary source of care for patients who are healthy and who may not need to be seen for another billable service within the next three months; these patients would not be attributed to the physician under the current methodology. Conversely, there is no way to indicate that the relationship between a patient and physician has ended, and that is also important to address since costs beyond that endpoint would no longer be within the control of the physician. Because all attribution remains retrospective, no physicians would have any certainty as to whether they would or would not be attributed patients until after the performance period ends.

For these reasons, it is essential to modify the attribution rules to include a mechanism for using patient relationship codes and to seek input from physician specialty societies about how to make this new attribution method work effectively. Primary care physicians and specialists, as well as QHPs, should be able to inform accurate attribution of patients and cost measures by including the applicable patient relationship code on their claims. The Medicare Access and CHIP Reauthorization Act provides that "[i]n order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall, as the Secretary determines appropriate–(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners" (42 U.S.C. 1395w–4(r)(5)(A)(i)). The statute

clearly envisioned that the patient relationship codes would be used for patient attribution of cost measures, and this is particularly important for a cost measure as broad as the TPCC. The current attribution rules merely make guesses, and often inaccurate guesses, about whether a patient's care is being managed by a particular physician. A far more accurate method would be to allow physicians to explicitly describe the nature of their relationship with a patient.

CMS and its contractor, Acumen, LLC, have stated that the reason for not using the patient relationship codes in the cost measure attribution methodology is that very few physicians and other eligible clinicians report these codes. But this is circular logic. The lack of reporting is due at least in part to the fact that the codes are not currently used in cost measure attribution and do not result in any additional payment or other resources. It is not surprising that busy physicians do not take the extra time to record a code when they know it will have no impact on anything. If physicians knew that their MIPS cost measure attribution would be more accurate and better reflect their clinical practice if they reported the patient relationship codes, the AMA believes many more physicians would report the codes, particularly as the cost measures account for 30 percent of MIPS final scores and MIPS penalties can be as large as -9 percent.

While we recommend that CMS examine approaches to promote and incentivize the use of the patient relationship codes, it is neither necessary nor desirable to mandate the use of patient relationship codes on all claims in order to utilize them to improve attribution. Using the patient relationship codes will require additional time by physicians and changes in their billing systems, and that may not be feasible today for many physicians, particularly those in small and under-resourced practices. If a physician does not report a patient relationship code for a particular patient, the current attribution rules can continue to be used to determine what portion of costs associated with that patient's overall care, if any, should be attributed to that physician.

Adjusting Candidate Event Logic

During the March 2024 TEP meeting, there was also discussion about options to simplify TPCC's candidate event logic. The AMA appreciates that CMS and Acumen are considering ways to simplify the TPCC methodology, which is so complex and opaque that very few physicians could anticipate whether they would be attributed a patient at the time of the patient's visit. **We support the proposed refinements to remove the "+/- three days, Any TIN" rule from the candidate event logic and to add an included specialty check on the confirming claim of the candidate event.**

However, as discussed previously, we believe including the patient relationship codes in the TPCC attribution methodology could do more to simplify and significantly improve the accuracy of attribution and candidate event logic of TPCC, as long as the enhanced methodology is developed in collaboration with the physician specialty societies.

Allowing physicians and other eligible clinicians to prospectively identify their relationship with a patient would provide several benefits, including: (1) improving accuracy of attribution by better distinguishing the relationship between the patient and the physician at the time of the service, (2) remedying flaws in the TPCC attribution methodology by allowing physicians to indicate when their relationship with a patient has changed, and (3) providing physicians greater certainty about which patients will be attributed to them for the MIPS cost measures. Notably, incorporating patient relationship codes into attribution would help resolve CMS' concerns that simplifying the candidate event logic could exclude healthy patients, because primary care physicians and other specialists managing well-controlled chronic conditions could report that they are the primary source of care for those patients. For example, a physician could be actively managing the care of a patient through patient portal message exchanges and

prescription refills that are not captured in claims data, so the only way to know about the actual relationship between the physician and patient would be through the use of patient relationship codes.

Using Cost Measures to Assess Value

During the March 2024 TEP meeting, Acumen presented a concept that would use the existing administrative claims-based cost measure development process to develop a cost measure and a companion quality measure at the same time. Specifically, Acumen presented a case study on how a sepsis mortality measure could be developed using almost all the same specifications of the Sepsis episode-based cost measure.

Though we do not support the approach presented by Acumen for the reasons explained below, we were glad to see discussion about adding measures to MIPS on an information-only basis. The AMA has made this recommendation in the past and been told that CMS does not have statutory authority to include a measure that does not count toward the MIPS score and payment adjustment. For example, the AMA opposes the Psychoses episode-based cost measure that holds inpatient psychiatrists accountable for all services after the patient leaves the hospital, regardless of whether there are community-based supports that accept Medicare. We previously recommended that the measure be implemented on an information-only basis but were told that was not possible given statutory constraints. We are glad that CMS has apparently reevaluated its legal analysis and determined that the agency can adopt measures on an information-only basis. There are some measures that would be helpful to track and to see the data to improve patient care, but not if it means penalizing physicians using measures that are not sufficiently reliable or that can be significantly affected by available community resources and other factors outside of a physician's control.

Furthermore, we urge Acumen to provide more information about their work on aligning cost and quality measures. For instance, it would be useful to know if Acumen has calculated and evaluated cost and quality measures for the same conditions and episodes and whether they cover the same timeframe, same physicians or eligible clinicians, same panel of patients, and same sets of services.

Identifying and Prioritizing Claims-Based Outcomes

While the AMA believes it is important to align cost and quality in MIPS, that cannot and should not be done using mortality or other "outcomes" measures using administrative claims data. **We strongly urge CMS and Acumen to abandon any further efforts to develop mortality measures for physicians and focus instead on quality process measures that are designed to ensure that lower costs are not the result of undertreatment.** Adding additional claims-based outcome measures to the program will only exacerbate the ongoing issues with attribution and risk-adjustment that we currently see with claims-based cost measures. Measure developers moved to registry and electronic/digital quality measures because they are much richer and more granular sources of data and allow an accurate determination of which physicians were involved in a patient's care. Claims data cannot do this.

The issue with mortality that *should* be addressed is that under the current cost measures, a hospital or physician is penalized for spending more to keep patients from dying because costs associated with patients who survive are included, but the costs associated with patients who die are not. Acumen's analysis that was presented to the TEP does not address this problem. We also believe Acumen may have misinterpreted the direction of the TEP. The issue that prompted this presentation was a discussion at a previous TEP meeting about whether patients who die should continue to be excluded from cost measures. Rather than simply including or excluding those patients from the current cost measures, the

TEP recommended exploring whether it would be possible to create a separate way of measuring costs and quality associated with patients who die. However, Acumen did not propose ways of measuring "episodes ending in death," but instead proposed measuring the rate at which a physician's patients die.

What is worse, the proposed mortality measure did not examine or address the many serious problems that are known to be associated with trying to measure and hold physicians accountable for mortality. The AMA recommends reviewing the two articles below, which provide more information about why it is inappropriate to try and measure performance on mortality at the physician level:

- Fernandez G, Narins CR, Bruckel J, Ayers B, Ling FS. Patient and Physician Perspectives on Public Reporting of Mortality Ratings for Percutaneous Coronary Intervention in New York State. Circ Cardiovasc Qual Outcomes. 2017 Sep;10(9):e003511. Doi: 10.1161/CIRCOUTCOMES.116.003511. PMID: 28893831.
- Salet N, Stangenberger VA, Bremmer RH, Eijkenaar F. Between-Hospital and Between-Physician Variation in Outcomes and Costs in High- and Low-Complex Surgery: A Nationwide Multilevel Analysis. Value Health. 2023 Apr; 26(4):536-546. Doi: 10.1016/j.jval.2022.11.006. Epub 2022 Nov 25. PMID: 36436789.

Aligning Cost and Quality with Measure Specifications

The only way to fairly measure the performance of physicians on cost is to ensure: (1) that the cost measures assess the aspects of cost that physicians can control, and (2) that there are also quality measures that can identify whether reductions in cost are being achieved by delivering fewer of the services that patients need to achieve good outcomes. Although it sounds attractive to use outcome measures to assess the quality of care, a physician cannot control all the factors that affect a patient's outcome. No risk adjustment methods can adequately adjust for all the uncontrollable factors, and risk adjustment methods based solely on information on claims data will perform particularly poorly. Just as cost measures must be focused on the aspects of cost that physicians can control, quality measures also have to focus on the aspects of care that physicians can control, rather than outcomes that they cannot control.

Cost and quality measures should be developed as a logically related bundle, rather than merely identifying quality measures and a cost measure for the same condition and assuming they are complementary. It would be particularly inappropriate to pair cost and quality measures that are based on different groups of patients and physicians, different time frames, or differences in services or other data elements, because it is then impossible to say for sure whether lower costs are being achieved at the expense of quality for some patients, or whether higher quality is being achieved through spending that is not included in the cost measure. The TPCC measure is already much too broad, and there is no group of quality measures or aggregate measure that could appropriately protect against inappropriately low spending in such a broad measure. This problem is exacerbated under the current approach of monthly benchmarking on costs, which is contrary to how the quality measures are reported. **The AMA urges CMS to refine its approach and implement MVPs that are focused on specific patient conditions and that use logically related cost and quality measures specific to those conditions.**

Assessing Performance with the Companion Metric

MVPs were intended to be a mechanism for aligning cost and quality measures. As a CMS contractor, Acumen should not be developing an additional or different approach. Rather, Acumen should assist CMS to identify and develop more and better episode-based cost measures to replace TPCC. It should also identify the types of services included in each episode-based cost measure where undertreatment of patients could result in lower costs and identify or develop measures of whether cost reductions are being achieved by reducing the number of necessary services delivered.

Lack of Timely Data to Reduce Avoidable Costs for Medicare and Patients

Regardless of how well designed the MIPS cost measures are, an overarching problem is the lack of timely feedback to physicians. Currently, CMS provides physicians with an annual MIPS Feedback Report that includes information about their performance on MIPS measures six to 18 months after they have provided the services to patients. Because only CMS can calculate the cost measures, physicians have no way of knowing at any point during the performance year how they are performing on any of these cost measures. Yet, these measures collectively account for 30 percent of their total MIPS score.

Physicians do not know which cost measures they will be measured on, which patients will be 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. Without this information, physicians have no way to monitor their current performance, identify opportunities for improving the efficiency of care delivery, and avoid unnecessary costs for the Medicare program and patients. **To drive improvements in cost measure performance and reductions in avoidable spending, CMS should provide physicians with quarterly feedback reports during the performance period about their cost measures. These reports could be similar to the field testing reports that its measure development contractor, Acumen, LLC, provides when cost measures are in development.**

The AMA appreciates CMS' attention to opportunities to improve the MIPS Cost Performance Category and thanks the agency 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.

Sincerely,

James L. Madara, MD