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
200 Independence Avenue, SW
Washington, DC 20201

Re: Existing and 2025 Candidate Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs)

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to reiterate and highlight our ongoing concerns with the existing and 2025 candidate Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs), as well as recommend an alternative framework for MVPs that addresses many of the pitfalls of the current approach. We are hopeful the Centers for Medicare & Medicaid Services (CMS) will address our concerns and recommendations in the 2025 Quality Payment Program (QPP) proposed rule.

The AMA appreciates the ongoing dialogue with CMS on MVPs, but the AMA and medical specialty societies continue to believe that the best way to address the problems with CMS' existing MVP approach is to create separate MVPs for individual health conditions, episodes of care, and major procedures, specifically for areas that are high volume conditions and procedures—similar to the current MVP for Lower Extremity Joint Repair. **However, based on ongoing conversations and meetings we have had with CMS, as well as CMS stating that it does not want a large portfolio of MVPs, we have developed an alternative MVP framework.** This alternative framework categorizes quality and cost measures into condition-specific subdivisions within a broader MVP. Physicians who specialize in treating a particular condition would be able to clearly identify the available measures for that condition and register to be held accountable for those condition-specific quality and cost measures within the MVP. By creating MVPs through the proposed framework, CMS and physicians could also more easily identify and remedy gaps in measurement and scoring challenges, such as no or limited condition specific measures or measures without a benchmark. **We believe this framework helps address many of the problems with the current MVPs for many specialists, is feasible for CMS to implement, and helps inform patient decision-making.** We encourage CMS to obtain feedback on the framework in the proposed rule.

While we believe this approach holds significant promise to deliver more value to physicians who participate in MVPs and their patients, we do not believe it will resolve all the problems with the *Surgical Care MVP Candidate*. As discussed in previous correspondence, we believe this draft MVP inappropriately lumps multiple specialties (e.g., general surgery, colorectal surgery, neurosurgery, and

thoracic surgery, etc.) into a single MVP without a basis in how care is delivered to patients. **We recommend CMS not move forward with the Surgical Care MVP Candidate as currently drafted. At a minimum, CMS should work with the national medical specialty societies to develop one MVP for each specialty using the alternative framework outlined below that groups measures by the major conditions that specialty treats.** With the exception of the surgical care MVP Candidate, the AMA believes that CMS and the specialties can work together to modify the other existing or proposed MVPs within this framework. AMA's goal is to have MVPs that work for patients, physicians, and CMS.

Condition-Stratified Framework for Aligning Quality and Cost in Specialty MVPs

While there is no one-size-fits-all approach to MVPs that will work for every medical specialty, we believe that an MVP Framework that prioritizes alignment of quality and cost measures will alleviate many of the concerns with the existing MVP approach that ignores the variation in care provided by subspecialists and to different patient populations. The framework also takes into consideration independent and small physician practices, as it is premised on maintaining the finalized flexibilities for small practice scoring.

Instead of the current approach of having a long list of quality measures in the MVP ordered by Measure ID, we suggest that CMS organize the quality measures into categories, each of which is relevant to a particular patient condition or an episode of a particular type of treatment. If applicable, cross-cutting quality measures, such as depression screening and advance care planning, would be in a separate category. The available cost measures, and the relevant improvement activities, would then be placed into the same condition or procedure categories, i.e., an episode-based cost measure specific to a particular condition or procedure would be shown in the same category as the quality measures for that condition/procedure.

For example:

- In the *Advancing Care for Heart Disease MVP*, the quality measures would be grouped based on whether they applied to coronary artery disease, heart failure, atrial fibrillation, or other heart conditions. The measures could be further subdivided based on whether they relate to medical management of the condition or an interventional procedure (e.g., percutaneous coronary intervention (PCI) or ablation). The heart failure cost measure would be placed in the same category as the quality measures applicable to heart failure, and the PCI cost measures would be placed in the category for intervention related to coronary artery disease. This is shown in the attached table.
- In the proposed candidate MVP for *Comprehensive Ocular Care MVP Candidate*, we recommend CMS restructure it into subcategories of measures related to cataract, glaucoma, retina and vitreous conditions, or other eye conditions. The cataract episode-based cost measure would be grouped with the cataract quality measures. Please see attached table.

We also would like to see CMS **develop MVPs that involve multiple specialists who coordinate care for patients with a particular condition, during an episode of care, or for a procedure.** For example, as discussed at the February 26, 2024 MVP Round Table with CMS, the AMA supports the proposal submitted by the American Association of Neurological Surgeons and Congress of Neurological Surgeons that would add spine surgeons to the Musculoskeletal Care MVP. This would be more reflective of real-world, multi-disciplinary, and team-based musculoskeletal care than grouping them into an overly broad surgery MVP.

Quality Measure Scoring

This approach would also enable modifications to the scoring rules for MVPs to achieve more appropriate quality scores for MVP participants, including:

Few relevant measures:

If there are fewer than four quality measures in the MVP category for the specific type of condition that a physician manages or the specific procedure the physician performs (subcategory), then the physician would only be required to report those measures, rather than being forced to use generic measures in the MVP that are not relevant to their care or to not participate in the MVP at all.

Topped out measures:

To ensure equitable scoring rules and incentivize participation in MVPs, topped-out measures would not be capped.

New or existing measures or measures without a benchmark:

If there are few or no benchmarked outcome measures or high priority measures relevant to the condition(s)/procedures the physician manages/delivers, then the physician could be given maximum credit for submitting the unbenchmarked measures for a longer period in order to encourage submission of enough cases to develop a benchmark.

Measures with substantive changes:

The current approach to truncate the performance period to nine months may not yield sufficient data to establish reliable measure scores and/or benchmarks. Alternatively, if CMS cannot calculate a benchmark from truncated performance data, CMS creates a performance period benchmark. The scoring rule would lead to uncertainty and potential inequities with achieving the performance threshold. To encourage reporting on measures with substantive changes that need a new benchmark, physicians should be given maximum credit for submitting the measures to encourage submission of enough cases to allow CMS to develop a benchmark for future years, just as with the new or existing measure recommendation discussed previously. The current approach to truncate the performance period to nine months may not yield sufficient data to establish reliable measure scores and/or benchmarks.

Cost Measures

The AMA remains extremely concerned about the MIPS cost measures. We have long opposed inclusion of the Total Per Capita Cost (TPCC) in MIPS as it holds physicians accountable for costs over which they have no control because the services are ordered, provided, and priced by others, and for which they receive no data that might allow them to understand and influence their performance on the measure. We have also opposed the inclusion of TPCC in any MVPs that include other episode-based cost measures. If CMS continues to use TPCC in MVPs, we recommend that it be modified in several ways:

- Eliminate inappropriate attribution to specialists due to qualified health care professional (QHP) billing by (a) incorporating patient relationship codes/modifiers, (b) using place of service codes, and/or (c) identifying TINs that should otherwise be excluded if not for billing by QHPs.

- Exclude the cost of all preventive services from the measure in order to avoid penalizing physicians, including those who provide primary care, for delivering this high-value care, especially since any savings from preventive services are highly unlikely to be realized during the same performance year that the preventive services are provided.
- Disaggregate the total costs into subsets that are related to the conditions managed by different types of specialists, since it is those costs that each specialist can actually control. The disaggregated amounts would provide more meaningful and reliable measures of differences in practice than the current specialty adjustment and avoid holding specialists accountable for costs they cannot reasonably influence or control.

Finally, we are concerned about the Cost Performance Category resulting in MIPS scores that are inequitable for physicians and misleading for patients because of the limited portfolio of specialty-specific cost measures. For example, since only a subset of ophthalmologists is scored on the cataract surgery episode-based cost measure, other ophthalmologists will have more weight assigned to the Quality and Promoting Interoperability Performance Categories, which means that the MIPS scores for different ophthalmologists will reflect different components of value-based care. **CMS must prioritize development of additional episode-based cost measures.**

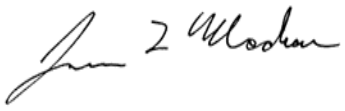
Additionally, while it is difficult to make a concrete recommendation to address this problem prior to the release of the 2022 QPP Experience Report and accompanying public use file, we continue to believe that CMS should consider alternative cost measure benchmarking approaches that will lessen the unpredictability and unfairness of the current Cost Performance Category. We also remain concerned that the cost measure benchmarks may be exacerbating the inequities in the program because they rely on a 10-decile methodology. For instance, given there is very little variation in costs in cataract surgery episodes and a low reliability threshold, we remain concerned that the decile scoring approach may be penalizing physicians for outlier episodes of care or for marginal differences in care. There is no requirement under the Medicare Access and CHIP Reauthorization Act (MACRA) to use a 10-decile approach to scoring, and we urge CMS to explore alternatives.

Population Health Measures

While measuring improvement in population health is important, introducing additional, one-size-fits-all requirements rather than considering the measures for potential use into existing criteria and tailoring them to each MVP adds unnecessary complexity and is less effective at improving patient outcomes. For example, the population health measures are focused on hospital care that is not clinically relevant to ophthalmologists. While ophthalmologists and other specialists, including primary care, may be exempt from some of the measures, inclusion of these measures as a foundational layer would result in confusion and concern about the applicability of those measures and MVP. It also adds an additional category into the program with burdensome and uneven scoring rules that were never intended or required by Congress in the MACRA statute. Maintaining the foundational requirement just adds additional quality measure requirements and standards into the program and increases administrative burden. Because CMS has added this new foundational category, we believe it is not accurate to say that MVPs reduce the number of quality measures that a physician or group must report. In addition, given the measures are based solely on administrative claims, CMS is potentially introducing the same flaws we have repeatedly highlighted with the global cost measures into this new category. **Therefore, we urge CMS to remove the flawed population health measures and category as a foundational requirement as it fails to accurately capture quality.**

Thank you for considering our recommendations to improve the design of MVP and overall QPP. Please do not hesitate to contact Margaret Garikes, Vice President of Federal Affairs with any questions or to discuss further at margaret.garikes@ama-assn.org.

Sincerely,



James L. Madara, MD

Attachment

QUALITY & COST MEASURES IN CONDITION-STRATIFIED 2024 MVP FOR HEART DISEASE

SYSTEM	CONDITION	SERVICE	QUALITY Measures**	Outcome	Priority	Bench-mark	Topped Out or 7-Point Cap	COST
Heart Disease	Coronary Artery Disease	Medical Management	Q006: CAD: Antiplatelet Therapy				Topped	No Condition-Specific Measure
			Q007: CAD: Beta Blocker Therapy for Prior MI or LVSD				Topped	
			Q118: CAD: ACE or ARB Therapy					
			Q243: Cardiac Rehabilitation Referral from Outpatient Setting		Y			
			Q441: Ischemic Vascular Disease Optimal Control	Y				
		Intervention	Q243: Cardiac Rehabilitation Referral from Outpatient Setting		Y			Elective PCI
			Q441: Ischemic Vascular Disease Optimal Control	Y				STEMI with PCI
	Heart Failure	Medical Management	Q005: HF: ACE or ARB or ARNI Therapy for LVSD				Capped	Heart Failure
			Q008: HF: Beta-Blocker for LVSD				Capped	
			Q377: Functional Status Assessment for Heart Failure		Y	No		
			Q492: CV-Related Admission Rates for Heart Failure Patients	Y		?		
	Atrial Fibrillation	Medical Management	Q326: A-Fib: Chronic Anticoagulation Therapy			No		No Condition-Specific Measure
		Intervention	Q392: Cardiac Tamponade/Pericardiocentesis Following Ablation	Y		No		No Condition-Specific Measure
	Other (AMI, SVT, etc.)	Intervention	Q393: Infection After Cardiac Implantable Device	Y		No		No Condition-Specific Measure
Broad or Focused Services			Q238: Use of High-Risk Medications in Older Adults		Y	No		
Continuous or Broad Services for Patient*	Screening and Followup		Q134: Depression Screening and Follow-Up				Capped	Total Per Capita Cost Medicare Spending Per Beneficiary
			Q128: BMI Screening and Follow-Up				Capped	
			Q487: Screening for Social Drivers of Health		Y	No		
	Other		Q047: Advance Care Plan		Y		Topped	
			Q503: Gains in Patient Activation Measure Scores	Y		No		

* Not intended to be mandatory. The measures would only be used by physicians providing continuous or broad services to a patient, using the definitions in the Patient Relationship Categories adopted by CMS.
** Not an endorsement of measures. Broken down to demonstrate how the framework can be conceptualized based primarily on existing or proposed MVPs.

QUALITY & COST MEASURES IN 2024 MVP FOR OCULAR CARE: Our Prelimary Suggestions

SYSTEM	CONDITION	SERVICE	QUALITY: Measures	Outcome	Priority	Bench-mark	Topped Out or 7-Point Cap	COST
	Cataract and Anterior Segment*		Q191: Visual Acuity After Cataract Surgery	Y	Y		CQM Topped	Routine Cataract Removal with IOL Implantation Cost Measure
			Q389: Planned vs Final Refraction After Cataract Surgery	Y	Y			
			IRIS54: Complications After Cataract Surgery	Y	Y			
			IRIS61: Visual Acuity Improvement Following Cataract Surgery and Minimally Invasive Glaucoma Surgery	Y	Y	No (new, 7-pt floor)		
			IRIS62: Regaining Vision After Cataract Surgery	Y	Y	No (new, 7-pt floor)		
	Glaucoma	Medical Management	Q012: Optic Nerve Evaluation in Glaucoma				Topped	No Condition-Specific Measure
			Q141: Reduction of Intraocular Pressure or Plan of Care	Y	Y			
			IRIS2: Reduction of Intraocular Pressure	Y	Y			
			IRIS39: Intraocular Pressure Reduction After Procedure	Y	Y	No		
			IRIS61: Visual Acuity Improvement Following Cataract Surgery and Minimally Invasive Glaucoma Surgery	Y	Y	No (new, 7-pt floor)		
	Retina	Medical & Surgical	Q019: Communication About Retinopathy with Diabetes Mgt Phys.		Y		CQM Capped	No Condition-Specific Measure
			Q117: Diabetes Eye Exam				CQM Capped	
			Q384: No OR Return After Retinal Detachment Surgery	Y	Y		Capped	
			Q385: Visual Acuity Improvement After Retinal Detachment Surgery	Y	Y			
			Q499: Appropriate screening and plan of care for elevated intraocular pressure following intravitreal or periocular steroid therapy			No (new, 7-pt floor)		
			Q500: Acute posterior vitreous detachment appropriate examination and follow-up			No (new, 7-pt floor)		
			Q501: Acute posterior vitreous detachment and acute vitreous hemorrhage appropriate examination and follow-up			No (new, 7-pt floor)		
			IRIS13: Loss of Visual Acuity in Diabetic Macular Edema	Y	Y		Topped	
			IRIS35: Improvement of Macular Edema in Patients with Uveitis	Y	Y	No		
			IRIS38: Endothelial Keratoplasty, Dislocation Requiring Surgical Intervention	Y	Y	No		
			IRIS58: Improved Visual Acuity After Vitrectomy	Y	Y			
	Cornea		IRIS1: Endothelial Keratoplasty - Post-operative improvement in best corrected visual acuity to 20/40 or better	Y	Y	No		No Condition-Specific Measure
			IRIS38: Endothelial Keratoplasty, Dislocation Requiring Surgical Intervention	Y	Y	No		
	Other (Reconstructive, Pediatric, Neuro, Immunology)		We can add a section for pediatric ophtho with 117, IRIS17, IRIS50, IRIS54, IRIS61, IRIS62 Uveitis-Immunology: 499, IRIS17, IRIS35 Oculoplastics: 137, 357, 397 Neuro: 318, 419					No Condition-Specific Measure
	Refractive		IRIS23: Refractive Surgery: Patients with a postoperative uncorrected visual acuity (UCVA) of 20/20 or better within 30 days	Y	Y			No Condition-Specific Measure
			IRIS24: Refractive Surgery: Patients with a postoperative correction within + or - 0.5 Diopter (D) of the intended correction	Y	Y	No		
			IRIS38: Endothelial Keratoplasty, Dislocation Requiring Surgical Intervention	Y	Y	No		
General**	Preventive Care and Screening***		Q012: Optic Nerve Evaluation in Glaucoma				Topped	
			Q117: Diabetes Eye Exam				CQM Capped	
			Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention					
			Q487: Screening for Social Drivers of Health		Y	No (new, 5-pt floor)		
	Other***		Q238: Use of High-Risk Medications in Older Adults		Y	No		
			Q130: Documentation of Current Medications in the Medical Record		Y		Capped	
			Q374: Receipt of Specialist Report		Y	No (MIPS CQM) Yes (eCQM)		

* Measures 303 and 304 were developed for PQRS and are not appropriate for MIPS, per the measure steward.
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*** Not an endorsement of measures. Broken down to demonstrate how the framework can be conceptualized based primarily on existing or proposed MVPs.