James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT
james.madara@ama-assn.org

April 11, 2024

The Honorable Jonathan Blum
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

Dear Principal Deputy Blum:

On behalf of the physician and medical student members of the American Medical Association (AMA), I would like to thank you for your ongoing dialogue with the AMA regarding the aftermath of the Change Healthcare cyberattack. We greatly appreciate the Administration's efforts to try to address the challenges. As we have all seen, the Change Healthcare cyberattack clearly demonstrated the financial fragility of many small practices, which underscores the need to ease administrative burdens and penalty risks under the Merit-based Incentive Payment System (MIPS).

When the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) passed, the AMA believed that by 2024 MIPS would accurately measure quality and cost, and physicians who would be subject to the steep MIPS penalties would be outliers. Unfortunately, that is not the case. There are so many problems with both the cost and quality categories that MIPS is meaningless for both patients and physicians. A 2022 study in *JAMA* found that MIPS scores are inconsistently related to performance.[1] We believe that physicians who will most likely be subject to significant MIPS penalties are those in practices that are smaller, rural, and/or treating the underserved since the program requirements are so onerous, as detailed in a study finding the average compliance costs topped $12,000 per physician per year.[2]

Now, after several years of COVID-related flexibilities, physicians have suddenly been faced with a program that is very burdensome, not clinically relevant for them, and in which they can be subject to penalties of up to 9 percent based on costs over which they have no influence for patients that they do not know have been attributed to them. Furthermore, the MIPS program fails to provide patients with accurate information about which physicians are providing the best care while being mindful of the costs to the system.

Over the years, the AMA has provided many constructive solutions on MIPS to the Centers for Medicare & Medicaid Services (CMS) that aim to address these core issues with the program so it can more effectively evaluate and incentivize high-quality care, provide more timely, actionable data for physicians and patients, and minimize practice burden. Our MIPS recommendations have reflected significant input from medical specialty societies. Yet, CMS is frequently reluctant to make changes. At times, CMS staff

[1] https://jamanetwork.com/journals/jama/article-abstract/2799153.
[2] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947.

have told the AMA that the agency does not have statutory authority for the various policy changes we have brought to the table. Consequently, the AMA developed the attached chart with our recommendations as well as CMS' statutory authority to implement those policies. We shared the chart with the Center for Clinical Standards and Quality (CCSQ) and requested a meeting with CCSQ and CMS' Office of General Counsel (OGC) to discuss CMS' statutory authority. We were disappointed to learn that CMS' OGC would not participate in such a meeting. It goes without saying that it is very difficult to discuss statutory authority without the appropriate lawyers in the room.

Unfortunately, we do not have the luxury of time to fix MIPS. We anticipate the significant MIPS penalties will cause many physicians to sell their practices or go out of business. Therefore, the AMA wants to make you and other CMS leaders aware of our recommendations. We urge the agency to think outside of the box to incorporate as many of the attached recommendations as possible in the 2025 proposed physician fee schedule rule.

Thank you for your consideration of this critical matter. If you have any questions, please do not hesitate to reach out to Margaret Garikes, AMA's Vice President for Federal Affairs, at margaret.garikes@ama-assn.org.

Sincerely

James L. Madara, MD

Attachment

AMA MIPS Priorities for the 2025 MPFS Proposed Rule

1. **Cost measures –** The AMA identified numerous problems and unintended consequences with the MIPS cost measures in October 2023 and December 2023 letters to CMS and urged the agency to reweight this category or at least the affected measures until the agency could implement solutions to prevent unwarranted penalties stemming from the flawed cost measures. Furthermore, we reiterate our recommendation to remove TPCC from MIPS or, at a minimum, from MVPs with an episode-based cost measure. If it will continue to be included, it should be revised to correct attribution problems, exclude preventive services to avoid penalizing physicians for providing high-value care, and sub-group services and costs into patient condition categories so that it is clear which aspects of costs are more likely to be controlled or influenced by primary care services.

2. **Quality measures** – CMS should revise the scoring rules of topped out measures, measures without benchmarks (new or existing) and measures with substantive change to ensure equitable scoring rules. Therefore, we recommend CMS remove measure score caps from topped out measures. CMS should provide maximum points for reporting on new or existing measures without a benchmark, which should incentivize reporting on the un-benchmarked measures and allow CMS to have a sufficient sample size to create a benchmark for future reporting periods. 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. The current approach to truncate the performance period to nine months may not yield sufficient data to establish reliable measure scores and/or benchmarks and more than likely will change the year over year benchmark.

3. **MSSP Promoting Interoperability and APM CEHRT changes.** CMS should repeal two recently finalized policies that require all MSSP participants, regardless of QP status or track, to report MIPS PI data, and update the CEHRT use criterion for all Advanced APMs from 75 percent to "all" eligible clinicians, both starting with the 2025 performance year. CMS should instead take a two-pronged approach to validate CEHRT adoption and utilization across the ACO and APM community by: (1) instituting a "yes/no" attestation for ACOs to demonstrate CEHRT adoption and use and compliance with information blocking requirements; and (2) leveraging ONC CEHRT data that are already being collected directly from certified health IT developers, such as information from the new Insights Condition and Maintenance of Certification finalized in the Health Data, Technology, and Interoperability (HTI-1) Final Rule. At a minimum, given there is missing pertinent information related to model-specific CEHRT criteria and reasonable exceptions, CMS should delay both policies until at least the 2027 performance year and establish additional flexibilities, such as a time-limited exception for new ACOs or new participant practices in an ACO, as well as applying MIPS exemptions for small practices for the PI reporting requirements. On April 10, 2024, the AMA sent a sign-on letter to CMS Administrator Brooks-LaSure with support from more than three dozen national physician and health care organizations and over 100 ACOs, health systems, and hospitals calling for these changes.

4. **Administrative claims measures feedback*** – The AMA made several recommendations to improve MIPS data sharing in a September 2023 letter to CMS. The most urgent need is for quarterly feedback on administrative claims measures throughout the performance period. Because these measures are calculated by CMS using claims data, physicians have no way to know which measures they're being scored on, which patients are being attributed to them, and which services provided outside of their practice are being counted. To allow physicians to monitor and improve their performance, reducing avoidable costs for the Medicare program and patients, CMS should provide quarterly reports on all administrative claims measures in MIPS. *Note that we do not believe this would have to go through rulemaking but if CMS disagrees, this is a priority for the AMA for the 2025 MPFS proposed rule.

5. **MIPS Value Pathways (MVPs) reforms** – CMS has signaled that not only are MVPs the future of the MIPS program but also the agency intends to align it with all the other programs. Therefore, it is essential to get the MVPs right. We firmly 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. Following the MVP Summit with CMS and national medical specialty societies in late February, we are having ongoing discussions with the national medical specialty societies around a framework that would both fulfill this objective of aligning logically related quality and cost measures in MVPs while meeting CMS where it is in terms of not wanting to develop a large portfolio of MVPs. We have shared a draft of this framework with CCSQ staff and will have a final version to share soon. We also explained our concerns with the proposed MVPs and recommendations to improve them in this January 2024 letter to CMS.

AMA 2024 Analysis: MIPS Improvements and CMS Authority

1. **MIPS Cost Measures -** Fix the attribution, validity, and reliability problems with the MIPS cost measures and nullify their negative impact on Medicare physician payment and patient access to care until these issues can be properly addressed.

MIPS Improvement Recommendation	Reasoning/CMS Authority
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. For example, the cataract surgery cost measure benchmark may be based on flawed data as it includes episodes that erroneously exclude operating room expenses. Moreover, the measure specifications for the TPCC and MSPB measures from 2022 used for 2024 physician payment include deleted 2022 CPT codes. Taken together, it is questionable whether there are sufficient measures in this cost performance category that are applicable to the types of eligible professionals. The American Medical Association (AMA) documented the numerous problems with these measures in a December 18 letter and an October 27 letter to CMS.	**Section 1848(q)(5)(F)** of the Social Security Act (SSA) directs the Secretary to reweight the performance categories in cases in which there "are not **sufficient** measures… applicable and available to each type of eligible professional involved." In such cases, the "Secretary shall assign different scoring weights (including a weight of 0)… which may vary from the [specified] scoring weights…". 42 CFR 414.1380(c)(2)(i)(A) further clarifies the circumstances under which there are "not sufficient measures available and applicable under section 1848(q)(5)(F)." These include: • "For the cost performance category, CMS cannot reliably calculate a score for the cost measures that adequately captures and reflects the performance of the MIPS eligible clinician." 42 CFR 414.1380(c)(2)(i)(A)(2) • "Beginning with the 2020 MIPS payment year, for the quality, cost, and improvement activities performance categories, CMS determines, based on information known to the agency prior to the beginning of the relevant MIPS payment year, that data for a MIPS eligible clinician are inaccurate, unusable, *or otherwise compromised* due to circumstances outside of the control of the clinician and its agency." 42 CFR 414.1380(c)(2)(i)(A)(9) These provisions require CMS to reweight the Cost Category based on the fact that flaws in the costs measures make it impossible to reliably calculate a score for any of the affected cost measures that "adequately captures and reflects the performance" of the MIPS eligible clinician. As a result, these measures are inherently

	insufficient, triggering the statutory reweighting provision.
Resolve the problems with the cost measures for 2023 and future performance years. The agency should consult with the national medical specialty societies and clearly and transparently address how it will remedy the problems with these measures before the 2023 performance period feedback is released. We recommend that the agency release a fact sheet or Frequently Asked Questions document outlining the steps taken to ensure that the cost measures are not unduly and unfairly penalizing physicians for costs outside of their control and outside the intended specifications of the measure. If the necessary changes to address the identified problems with the cost measures cannot be made prior to impacting physician's MIPS scores and Medicare payment, then the Cost Performance Category should be reweighted (on the basis discussed above) or the measures should be excluded (based on the standard set forth in 42 CFR 414.1380(b)(2)(v)(A)) from all applicable MIPS eligible clinicians' scores.	Section 1848(r)of the SSA ["Collaborating with the physician, practitioner, and other stakeholder communities to improve resource use measurement"] contains numerous mentions of stakeholder consultation. For example, section 1848(r)(5)(D) states that the "Secretary shall seek comments from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use methodology established pursuant to this paragraph. In seeking comments the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms." The statutory requirement to seek comments from physician specialty societies regarding the development of the "resource use" (cost performance) methodology inherently requires CMS's consideration and incorporation of relevant and expert comments into the MIPS cost measures. We cannot imagine that Congress would require CMS to only seek, but not to consider and incorporate, these expert insights – as that would be a fruitless and wasteful exercise for all parties. Section 1848(q)(10) of the SSA also requires the Secretary to consult with stakeholders in carrying out the MIPS, including for the identification of measures and activities specified for each category, the methodologies for the composite performance score, and regarding the use of qualified clinical data registries. 42 CFR 414.1380(b)(2)(v)(A) provides, "Beginning with the 2024 MIPS payment year, if data used to calculate a score for a cost measure are impacted by significant changes during the performance period, such that calculating the cost measure score would lead to misleading or inaccurate results, then the affected cost measure

	is excluded from the MIPS eligible clinician's or group's cost performance category score. For purposes of this paragraph (b)(2)(v)(A), 'significant changes' are changes external to the care provided, and that CMS determines may lead to misleading or inaccurate results. Significant changes include, but are not limited to, rapid or unprecedented changes to service utilization, and will be empirically assessed by CMS to determine the extent to which the changes impact the calculation of a cost measure score that reflects clinician performance."
Establish a transparent annual process for updating the cost measure specifications due to changes in Current Procedural Terminology (CPT®) coding. The AMA would be happy to assist the agency and its measure developer in identifying CPT changes, additions, and deletions.	We believe that establishing a transparent annual process for updating cost measure specifications due to coding changes is a core competency of measure development and maintenance and should be expected as part of an annual review of the measures. If necessary, CMS can establish such an annual review through rulemaking.
Revise the cost measure benchmarking scoring approach and methodology. CMS calculates a single, national benchmark for each cost measure and uses a decile approach that assumes lower costs are better in the absence of any evaluation of whether the quality of care is better, or even the same. We fundamentally disagree with this premise and also question the usefulness of this decile approach when scores may differ dramatically based on relatively low cost differences (e.g., the difference between the 5th and 10th deciles for the screening colonoscopy measure is less than $200). We are also concerned that there may be variations in spending by region and specialty that are not factored into the benchmarks.	The statute is silent with respect to measure benchmarks. Broad authority is provided under 1848(q)(3) of the Social Security Act for the Secretary to establish performance standards with respect to measures and activities under MIPS. The 10-decile benchmark methodology and single, national average scoring were created by regulation and can, therefore, be modified by CMS through rulemaking. Accordingly, CMS should propose revisions to the MIPS cost measure benchmarks that reflect a range of reasonable costs that are permissible for high-quality performers.
Remove the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) Clinician measures. Measures should only cover costs that physicians can reasonably control. Neither the TPCC nor MSPB clinician measure, as currently specified, can meet that criterion because the measures hold physicians accountable for patients' medical conditions that are managed outside of their organization and for costs they cannot influence, such as drug prices.	CMS should propose removal of both cost measures in the 2025 Medicare Physician Payment Schedule (MFS) and Quality Payment Program proposed rule. In the 2020 MFS proposed rule, CMS considered removing the TPCC measure from MIPS. Ultimately, however, CMS decided against removing TPCC at that time because there were few episode-based cost measures that captured primary care spending. Now is the time to revisit whether TPCC is necessary. Unlike in 2020, there are now 23

	episode-based MIPS cost measures currently in use and many more in the development pipeline. Many of these measures address the costs of primary care. Further, including the Wave 4 episode-based cost measures (which CMS finalized to include in MIPS in the 2024 MFS rule) episode-based cost measures now account for 36.8 percent of all Medicare Parts A and B spending.

2. **MIPS Data -** Share meaningful MIPS performance data and Medicare claims data with physicians at least quarterly.

MIPS Improvement Recommendation	Reasoning/CMS Authority
Make Medicare claims data and meaningful MIPS attribution, measure, and performance data available on a rolling basis or, at a minimum, on a quarterly basis during the performance period consistent with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Currently, CMS provides physicians with an annual MIPS Feedback Report that includes information about their performance on MIPS metrics six to 18 months after they have provided a service to a Medicare patient. Taking the Cost Category as an example, the cost measures are calculated by CMS on the back end using claims. Physicians do not know at the time they provide services nor at any point during the performance year how they are performing on any of these cost measures that collectively account for 30 percent of their total MIPS score, including which cost measures they will be measured on, which patients are 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 performance, identify opportunities for efficiencies in care delivery, and avoid unnecessary costs.	MACRA requires CMS to provide timely MIPS performance feedback and Medicare claims data sharing. Section 1848(q)(12)(A)(i) of the SSA provides, "Beginning July 1, 2017, the Secretary shall make available timely (such as quarterly) confidential feedback to MIPS eligible professionals with respect to the [Quality and Cost] performance categories…" Section 1848(q)(12)(A)(iii) of the SSA provides, "the Secretary may use data, with respect to a MIPS eligible professional, from periods prior to the current performance period and may use rolling periods in order to make illustrative calculations about the performance of such professional." Section 1848(q)(12)(B)(i) of the SSA provides, "Beginning July 1, 2018, the Secretary shall make available to MIPS eligible professionals information, with respect to individuals who are patients of such MIPS eligible professionals, about items and services for which payment is made under this title that are furnished to such individuals by other suppliers and providers of services…" Section 1848(q)(12)(B)(ii) of the SSA defines the types of information to be provided as "the name of such providers furnishing such items and services to such patients during such period, the types of such items and services so furnished, and the dates such items and services were so furnished" for the "most recent period for which data are available (such as the most recent three-

	month period)" and "historical data, such as averages and other measures of the distribution if appropriate, of the total and components of allowed charges."
Correct inconsistencies in the MIPS public use data files as soon as possible, particularly regarding why so many national provider identifiers (NPIs) are missing from the National Downloadable File. Specifically, there is one file that contains the MIPS scores for each clinician but does not have any information about the clinician other than their name and NPI. The National Downloadable File that accompanies this MIPS score file has information about clinicians, such as their specialties and the names of the group or groups with which they practice. However, we have found that there are almost 100,000 NPIs with a MIPS score that are not included in the National Downloadable File. As a result, it is difficult to drill down in the data to better understand how small practices and rural practices, for example, are performing in MIPS and why this might be the case. Ensuring this data is accurate is critically important to ongoing efforts to understand and improve MIPS, which is a shared goal of the AMA and CMS.	Section 1848(q)(9)(D) of the SSA provides, "The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the MIPS, including the range of composite scores for all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category." The preceding paragraphs of 1848(q)(9) require the Secretary to make available on Physician Compare the composite score for each MIPS eligible professional and the performance with respect to each performance category and gives authority to the Secretary to make available performance with respect to each measure and activity. While no timing is specified, the information must be provided to the professionals in sufficient time to review it and submit corrections before the information is made public. While these provisions do not require CMS to post the clinician's specialty (or additional information) in connection with their MIPS scores, we believe that ensuring that such data is available and accurate in the National Downloadable File is essential to the goal of providing information to the public regarding quality performance and to enabling important research into quality performance trends.
Clarify the number of unique clinicians participating in MIPS in future Quality Payment Program (QPP) Experience Reports and include a breakdown of the different scores unique clinicians receive through multiple groups or Alternative Payment Models (APMs). CMS reports that almost 700,000 clinicians were included in MIPS in 2021. However, only about 600,000 different individuals participated in MIPS in 2021. In other words, the same physician is being counted multiple times if that physician bills for services through multiple organizations.	Section 1848(q)(9)(D) of the SSA provides, "The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the MIPS, including the range of composite scores for all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category."
Expand QPP Experience Reports to include detailed data from both QPP and claims data sources to inform opportunities to improve quality, reduce costs, and develop MIPS Value	Section 1848(q)(9)(D) of the SSA provides, "The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the MIPS, including the range of composite

Pathways (MVPs) and alternative payment models (APMs). Moreover, these reports should display longitudinal trends about whether quality or cost is improving or declining and provide a more complete picture of what makes a particular physician, group practice, or APM successful in MIPS. CMS should also include breakdowns by specialty and practice size. This type of granular data would also enable policy conversations about ways to consistently update and improve benchmarks over time, such as examining whether MIPS cost measures should move toward regional benchmarks similar to those used by accountable care organizations.	scores for all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category."

3. **MVPs -** Make MIPS Value Pathways (MVPs) less burdensome and more clinically relevant than traditional MIPS.

MIPS Improvement Recommendation	Reasoning/CMS Authority
Develop clinically relevant MVPs based on patient condition, episode of care, and clinical priority areas, not by specialty. Rather than arbitrarily limit MVPs to one per specialty, CMS should work with the national medical specialty societies to prioritize MVPs that hold physicians providing similar services accountable to one set of measures to 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. As currently drafted, most 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.	The statute is silent regarding the required focus of measures and/or measure weights. Section 1848(q)(2) provides broad authority to the Secretary to establish measures and activities under the performance categories (which has enabled the creation of MVPs). Section 1848(q)(10) of the SSA requires the Secretary to consult with stakeholders in carrying out the MIPS, including for the identification of measures and activities specified for each category, the methodologies for the composite performance score, and regarding the use of qualified clinical data registries.
Reduce the burden of MVP participants. 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. As CMS' reasons for moving to MVPs include better alignment of measures and activities and reducing reporting burden, we urge CMS to increase scoring simplicity and predictability by not imposing additional restrictions, such as requiring reporting on a certain minimum number of measures or by assigning varying measure weights. CMS should propose removal of these	The statute is silent regarding the required focus of measures and/or measure weights. Section 1848(q)(2) of the SSA provides broad authority to the Secretary to establish measures and activities under the performance categories (which has enabled the creation of MVPs). Section 1848(q)(3) of the SSA provides broad authority to the Secretary – providing only three, general guiding principles – to establish performance standards with respect to measures and activities. Therefore, it would be within the authority of CMS to make changes to

complicated scoring and reporting requirements via rulemaking.	performance standards for measures within MVPs.
Remove or tailor population health quality measures, which CMS has added as a foundational MVP requirement and new category on top of the general quality measure requirements and the three other MIPS categories. While measuring improvement on population health is important, this should be incorporated into existing criteria and tailored to the MVP to avoid unnecessary complexity. CMS should not require a population health measure for each MVP and/or add a new population health category. If the category is not eliminated, at a minimum, the population health measure should be tailored to the MVP.	The statute is silent regarding the required focus of measures and/or measure weights. Section 1848(q)(2) of the SSA provides broad authority to the Secretary to establish measures and activities under the performance categories (which has enabled the creation of MVPs). Section 1848(q)(3) of the SSA provides broad authority to the Secretary – providing only three, general guiding principles – to establish performance standards with respect to measures and activities.
MVPs should remain voluntary. Currently, MVPs are untested, require a significant leap in financial risk for eligible clinicians, and offer little upside compared to traditional MIPS. MVPs will increase administrative burden to most participants in MIPS who currently report as a group and would be required to form subgroups to participate in MVPs. Furthermore, there are not viable participation options for all specialists.	MACRA expressly provided a phase-in of MIPS requirements while gradually increasing the downside financial risk to participants. Requiring a substantial shift in requirements (i.e., making MVPs mandatory) when the financial risk is a -9 percent payment penalty conflicts with this deliberately phased-in policy approach. Additionally, the statute encourages MIPS participation by groups via combining tax identification numbers (TINs) rather than participation by subgroups (via subdividing TINs). Under 1848(q)(5)(I)(iii), the process for creating a virtual group includes combinations of TINs: "provide that a virtual group be a combination of tax identification numbers…". Section 1848(q)(1)(D) of the SSA requires CMS to establish a process to assess group practices on the quality performance category and enables the Secretary to establish processes for assessing group practices on the other categories.

4. **Quality -** Improve the clinical relevance and scoring accuracy of the MIPS Quality Performance Category.

MIPS Improvement Recommendation	CMS Authority
Lower the quality data completeness requirement to 60 percent of eligible patients.	Section 1848(q)(3) of the SSA provides broad authority to the Secretary – providing only three, general guiding principles – to establish performance standards with respect to measures and activities. Accordingly, the Secretary has authority to modify performance standards

	(including the data completeness requirement) for the quality measures.
Eliminate the topped out scoring cap of seven points. Due to the limited availability of measures for many specialties, the measure cap has resulted in physicians being unable to meet the performance threshold and being ineligible to earn an incentive. Topped out measure rules become more challenging when a physician is subject to re-weighting of one of the categories because the quality category then weighs more heavily, and the physician does not have a chance to earn maximum points. Existing policies for topped out measures significantly harm certain specialties.	1848(q)(2)(D)(i)(II)(aa) directs the Secretary to establish an annual final list of quality measures by updating the final list of quality measures from the previous year, to include removing quality measures, as appropriate. This process "may" (but is not required to) include removal of measures that are no longer meaningful (such as measures that are topped out). The statute, however, does not specify a timeline for removal nor does the statute mandate treatment of such an identified measure (while still on the list) for purposes of scoring or reporting. Accordingly, the Secretary has discretion regarding how to treat the measure for scoring purposes while it remains on the list. Additionally, while Section 1848(q)(3)(B) directs the Secretary to consider historical performance standards, improvement, and the opportunity for continued improvement in establishing performance standards, the statute does not further define these terms. Accordingly, the Secretary has discretion in evaluating and applying these considerations, and could consider other factors (including the availability of other measures for certain specialties) in determining how to apply these considerations as well.
Explore a new methodology for scoring measures. The current decile (10 point) approach arbitrarily distinguishes care and does not allow scoring to consider scientific evidence. The methodology also ignores how physicians are scored under Care Compare. As a result, physicians receive two separate and often conflicting scores—one for MIPS incentives and the other for public reporting on Care Compare. CMS should move to a uniform scoring policy across quality programs.	Section 1848(q)(3) of the SSA provides broad authority to the Secretary to establish performance standards with respect to measures and activities. The statute is silent with respect to benchmarks for scoring measures. The 10-decile benchmark methodology was created by regulation and can, therefore, be modified by CMS through rulemaking. Accordingly, CMS should propose revisions to the MIPS quality measure benchmarks that reflect a range of reasonable costs that are permissible for high-quality performers.

5. **CEHRT Utilization -** Maximize EHR usage while reducing reporting burden.

MIPS Improvement Recommendation	CMS Authority
All Promoting Interoperability (PI) measure reporting should be done through "yes/no" attestations.	CMS's authority to require Promoting Interoperability (PI) participation and certified electronic health record technology (CEHRT) use originates from the Health Information Technology for Economic and Clinical Health

	(HITECH) Act. Congress specified in HITECH that an eligible professional can satisfy the demonstration of meaningful use of CEHRT and information exchange through attestation (Section 1848(o)(2)(C) of the SSA). HITECH also permits reporting via "other means specified by the Secretary," granting the Secretary the authority to minimize CEHRT measure reporting through alternative, less burdensome methods.
Reverse mandatory reporting of PI data for all Medicare Shared Savings Program (MSSP) participants (regardless of Qualified APM Participant (QP) status), which is set to start in 2025. This moves the Quality Payment Programs in the wrong direction; if the goal is to tie 100 percent of Medicare payments to accountable care relationships by 2030, we should be shifting MIPS to emulate APM requirements, not vice versa. Furthermore, this change is directly at odds with the MACRA statute, which expressly states that qualifying APM participants are not MIPS eligible professionals, and therefore are not subject to reporting MIPS data. Instead, we believe CMS should leverage existing data from other sources, including ONC, to demonstrate CEHRT utilization while minimizing reporting burden on APM participants. To move toward APM adoption, CMS should expand the more flexible CEHRT standard for APM participants to MIPS participants, not move in the opposite direction.	The MACRA statute states "the term MIPS eligible professional does not include… an eligible professional… who is a qualifying APM participant… [or] a partial qualifying APM participant." Section 1848(q)(1)(C)(ii) of the SSA. Previous CMS guidance also states: "QPs receive the following benefits, which include burden reduction and financial incentives: Exclusion from MIPS reporting …" Where the MACRA statute discusses CEHRT requirements for Qualifying APM participants, it says only that "certified EHR technology is used." Section 1833(z)(2)(B) and (C). We believe this broad definition of CEHRT utilization was intentional to achieve MARCA's goal of minimizing burden to encourage APM adoption and that attestation to using CEHRT technology, as has been the standard up until now, is both a sufficient and effective method to demonstrate utilization of CEHRT for APM participants.
Restore 75 percent CEHRT utilization threshold for Advanced APM participants. The AMA supports CMS's change to make the definition of CEHRT more flexible so it can be customized to the specific uses and needs of each APM. However, we believe that the accompanying proposal to remove the 75 percent CEHRT utilization threshold is a mistake. Requiring "all" participants to utilize CEHRT unless they receive a specific exemption will introduce significant, unnecessary burden for APM participants and CMS staff, and potentially discourage participation in APMs. As noted above, we believe CMS should leverage existing data from other sources, including ONC, to demonstrate CEHRT utilization while minimizing reporting burden on APM participants.	Where the MACRA statute discusses requirements for Qualifying APM participants, it says only that "certified EHR technology is used." Section 1833(z)(2)(B) and (C). We believe this broad definition of CEHRT utilization was intentional to minimize burden and incentivize participation in APMs. We believe the burdensome requirements CMS continues to impose defies this statutory intent.