

March 4, 2020

The Honorable Seema Verma  
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: Improving MACRA Physician Cost Measure Development

Dear Administrator Verma:

On behalf of our physician and medical student members, the American Medical Association (AMA) greatly appreciates the time and effort that the Centers for Medicare & Medicaid Services (CMS) and its contractor, Acumen LLC, have invested in creating a process that allows for significant clinical input in the design of episode-based cost measures. **Now is the time to better inform and educate physicians about how they are evaluated on the 20 new and revised cost measures developed using this process, and how they would be evaluated on the five cost measures currently in development. In addition, the AMA recommends that CMS provide data to physicians participating in the Quality Payment Program (QPP) that will allow them to understand and improve their performance on the cost measures, and that CMS exclude Medicare Part D prescription drug costs from the measures.**

**1. Recommendation: CMS should educate and inform physicians about the cost measures.**

Physicians have become accustomed to choosing the quality measures on which their performance will be evaluated. We are concerned that many physicians may not understand how they are being evaluated on their claims data in the cost category because they do not choose which cost measures they are being evaluated on, nor do they affirmatively report data to CMS about these measures. CMS should take steps now to inform physicians about how they are evaluated on the Merit-based Incentive Payment System (MIPS) cost measures.

We urge CMS to make cost measure benchmarks available on a rolling, close to real-time basis during the actual measurement year, taking into account sample sizes, billing delays, and perhaps using ranges, not specific numeric targets, for performance and payment. Currently, there is a year-and-a-half delay between the measurement period and when benchmarks are published. For instance, the colonoscopy episode-based cost measure was introduced into MIPS for scoring purposes in 2019. However, physicians will not have access to the benchmarking information they need in order to know what their target spending in 2019 should have been until summer 2020, which is six months after the measurement year has ended. If providing rolling benchmark information is not yet feasible, CMS should, at a minimum, run the measures based on three prior years' Medicare claims data and publish the benchmarks for informational purposes. If physicians were able to see what the benchmarks would have been in 2016,

2017, and 2018 as a reference point, CMS would help to mitigate the lack of real-time benchmark information.

CMS should publish the latest benchmarking information in the cost measure specifications. We also urge CMS to add a section to each of the specifications to clearly identify the areas of overuse or excessive spending, as well as the opportunities (missed or realized) for cost savings, that contributed to variation among physicians in the costs incurred in each episode measure.

CMS should provide patient attribution information to physicians on a rolling, close to real-time basis during the actual measurement year. Because the cost measures utilize a new attribution methodology, there is significant uncertainty about which patients will be attributed to each measure. If CMS is not yet able to provide attribution information during the measurement year, the AMA recommends that CMS simulate the attribution methodology on three prior years' Medicare claims data and provide this information to physicians so they can become familiar with the QPP attribution methodology, their attributed patient population, and any turnover in their patient relationships from year to year. CMS should provide this information regardless of whether a physician falls above or below the case minimum in order to increase awareness of the measures. One effective way to display and disseminate this information to practicing physicians would be through the QPP portal.

**2. Recommendation: CMS should improve field testing to better inform physicians about measures in development and to solicit more input from practicing physicians before the measures are implemented in MIPS.**

While we appreciate that field testing has provided some opportunity for practicing physicians to preview their performance on certain measures, prior field testing was hampered by short timeframes, limited access to the feedback, and reports that were difficult to interpret. As CMS and Acumen LLC prepare for the next round of field testing, there are several opportunities to improve, including:

- Provide reference materials in advance of field testing and schedule webinars in the evening when physicians are more likely to be able to attend in order to receive meaningful feedback from practicing physicians about the measures;
- Allow physicians to continue accessing their field testing reports indefinitely via an archive on the QPP portal;
- Present cost measure data in more user-friendly formats so that clinicians can easily understand what they are being measured on, which patients are attributed to them for which measures, and how they would perform relative to other similar clinicians;
- Assist physicians who experience difficulty accessing their reports via the QPP portal;
- Solicit feedback about the construction and validity of the measures for a minimum of 90 days; and
- Respond timely to feedback from stakeholders and re-engage the measure work groups to incorporate changes before measures are proposed for implementation.

The AMA is happy to partner with CMS to get the word out about the measures and field testing and to host an in-person briefing for specialty societies' representatives so they can learn more about measures, the timing and results of field testing, and also understand the reports, which will assist CMS in more effective physician engagement.

**3. Recommendation: CMS should provide interactive, affordable ways for physicians to analyze their MIPS Feedback Reports to understand and improve their performance.**

We recognize the challenge of balancing the goal of providing as much data as possible with the goal of simplicity and enhanced usability. We appreciate CMS' efforts to provide more detailed data in the 2018 MIPS Feedback Reports, such as demographic and clinical characteristics for attributed beneficiaries, costs related to services billed by the clinician, and utilization of hospital and post-acute care. However, this information can be difficult to interpret and act upon because it is not accompanied by comparisons, definitions, or summaries to help identify trends across the data.

We continue to urge CMS to present claims data in conjunction with more digestible elements, such as summaries, so physicians can easily understand what they are being measured on, how they are performing relative to other similar physicians, and what they are supposed to be doing with this data to improve their performance and reduce costs. With episode-based cost measures, there will be opportunities to distill the data around an episode, condition, or specialty to improve the actionability of the information. Also, to assist physicians with accessing and reviewing claims data, CMS should partner with its technical support contractors.

Physicians need to see and learn from a wide variety of scenarios to understand the new cost measures. A gamification approach, using CMS-developed tools, which enables them to create "synthetic" patients and apply therapies and see how the expected costs would change would be very helpful as they strive to balance cost, quality, and risk.

**4. Recommendation: CMS should review cost measure data and field-testing feedback to make sure the measures are valid in that they measure true differences in costs between physicians for the same episodes of care.**

In addition to using the cost measure data to better inform physicians about their performance and how they can improve and lower costs, CMS should review all of this data and the feedback received during field testing to ensure the measures meet face validity in that they measure true differences in costs between physicians for the same episodes of care. Was the variation in spending between physicians preventable? Were there legitimate reasons, not captured using the measure's risk adjustment methodology, that cause patients to appear to be high cost or to have higher-than-expected costs? Did the benchmarks identify areas of overuse or did they arbitrarily distinguish physicians due to limited variation? We urge CMS to continue to scrutinize these measures beyond their initial development phase and to respond rapidly to concerns that these measures are not fairly, and accurately distinguishing physicians based on their costs.

**5. Recommendation: CMS should provide detailed data from both QPP and claims data sources in the QPP Experience Report to help specialty societies educate their members about episode-based cost measures and to develop and maintain corresponding quality measures, APMs, and MIPS Value Pathways (MVPs).**

In addition to providing physicians with useful cost measure performance feedback, we urge CMS to provide physician specialty societies with detailed QPP and administrative claims data. Specialty societies are eager to delve deeper into the data and analytics to better understand opportunities for efficiency improvements, to educate their members, and to advocate for program changes. More specialty-specific

and condition-specific data from both the QPP and claims data sources will help specialty societies understand and target opportunities for high quality, cost effective care in MIPS, MVPs, and APMs.

The most effective way to provide additional data is to build on the QPP Experience Report and Appendix. Here are five recommendations to improve the cost measure information provided in the QPP Experience Report and Appendix:

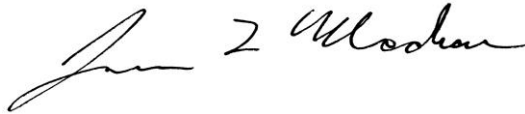
1. The following data points would be helpful to see reported by specialty. CMS has previously provided specialty-specific breakdowns in the PQRS Experience Reports and Quality and Resource Use Reports (QRURs), which are useful guideposts for the types of data that would be helpful to include in the QPP Experience Report and Appendix.
  - a. Average overall MIPS scores and payment adjustments.
  - b. Average scores for each year in each of the categories.
  - c. Percent of each specialty with negative versus positive payment adjustments.
  - d. Attribution and average scores for cost measures.
2. CMS should compare MIPS scores, payment adjustments, category performance, and APM participation rates by site of service.
3. We encourage CMS to include information about the administrative claims measures, including all-cause readmission, total per capita cost, and Medicare Spending Per Beneficiary. It would be helpful to see the average score by specialty, geographic location, and practice size.
4. CMS should provide cost performance distribution in a format like the charts in the QRURs that showed the midpoint and distribution. If CMS could break these down by measure and different demographics (specialty, practice size, etc.) that would be helpful. If not, even the aggregate performance range would be useful.
5. CMS should examine closely the data and report observed associations, if any are present or not, between cost, quality, outcomes and unintended consequences.
- 6. Recommendation: CMS should exclude the costs of Part D drugs from MIPS cost measures.**

We are concerned that the addition of prescription drugs to the cost measures, which are still immature and not yet well understood, will only exacerbate current inequities in the program. Inclusion of medications would penalize physicians for something over which they have no control. Drug manufacturers and payers, in this case CMS and Medicare Prescription Plans, negotiate coverage and price, not physicians. To hold a physician accountable for transactions that they are not a part of is fundamentally problematic. In this scenario, one presumes that patients and physicians have information about coverage, formularies, out-of-pocket costs and list prices at the point of care, which is not true in most cases. Finally, the addition of medication costs would add a lot of complexity to the measures at a time when they are still new and not well understood.

The Honorable Seema Verma  
March 4, 2020  
Page 5

Thank you for your consideration of our recommendations and comments about the ongoing MACRA cost measure development work. If you have any questions, please contact Margaret Garikes, Vice President, Federal Affairs at [margaret.garikes@ama-assn.org](mailto:margaret.garikes@ama-assn.org) or 202-789-7409.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is written in a cursive, flowing style.

James L. Madara, MD