AMA
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The Honorable Seema Verma
Administrator
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Verma:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the policies considered at the Merit-based Incentive Payment System (MIPS) Value Pathways Town Hall on January 7, 2021. The AMA continues to believe that the MIPS Value Pathway (MVP) has the potential to be a turning point in MIPS by reducing burden and allowing clinicians to focus on patient outcomes related to a condition, public health priority, or episode of care. The high-level framework outlined by CMS in the two prior Quality Payment Program rules is an important step in the right direction, but we believe that MVP needs to be structured appropriately to effectively improve the relevance of MIPS to clinical practice and reduce unnecessary paperwork burden.

Our principal recommendation to CMS is that MVP needs to pivot away from the status quo and siloed approach in MIPS in order to be successful. Merely grouping existing quality and cost measures with improvement activities under the umbrella of a measure set paired with a problematic population health measures and Promoting Interoperability will not achieve CMS' aims for MVP. Specifically, we strongly recommend that CMS ensure that MVP and subgroup participation is voluntary; establish a streamlined and flexible subgroup election and reporting process; incorporate the patient voice by focusing on measures relevant to patient outcomes and episodes of care; partner with specialty societies to expedite development of new cost measures; and incentivize MVP participation by phasing in MVPs, reducing reporting burden, and awarding multi-category credit for aligned measures across MIPS categories.

As detailed in the following sections, the AMA makes the following recommendations to CMS when considering implementation of a subgroup reporting option, MVP design, and MVP scoring:

- The AMA reiterates our support for operationalizing a subgroup reporting option that would facilitate participation in MVP by specialists who may be practicing within multispecialty groups. However, we do not support mandating subgroup reporting.

- CMS should allow sufficient time to make the necessary changes to the technical infrastructure and test health IT systems against the new updates, which will directly impact when third-party intermediaries, electronic health record (EHR) vendors, and physicians can adopt subgroup reporting.

Changes will also impact intermediaries reporting of MVP performance categories on behalf of physicians. It is our understanding vendors will need a minimum of a year to make the necessary changes to support MVP.

- The AMA remains concerned with CMS' continued emphasis that MVPs must include population health administrative claims measures as a foundation to MVPs. Population health measures move the MVP concept away from incorporating the patient's voice, measuring clinical conditions and outcomes, and generating real-time feedback.

- MVPs should serve as both a long-running, performance-based option to improve physicians' experience in MIPS and as a steppingstone for clinicians moving from participation in separate, unrelated MIPS measures to participation in an Alternative Payment Model (APM).

- The AMA does not support retiring traditional MIPS. In a sign-on letter to CMS sent in April 2020, the AMA joined 37 national medical specialty societies in strongly urging CMS to make MVP participation voluntary and to incentivize physicians to opt-in to an applicable MVP, if available.

- The best way to ensure simplicity in MVPs is to not require reporting on a certain minimum number of measures, type or focus of measures or assign varying weight. CMS has tried over years to similarly structure the physician programs which resulted in an administratively burdensome program and regular complaint of reporting for the sake of reporting.

- The make-up of the MVP, including the number of measures and activities within an MVP, should be determined by the specialty society developing the MVP, based on the MVP's clinical focus and what is most appropriate to measure and improve patient care.

- To further reduce complexity and allow physicians to better predict how they will perform under MIPS, we recommend that CMS move to reporting points in the Quality and Cost categories and yes/no attestation-based scoring in Promoting Interoperability (PI) and Improvement Activities (IAs). Physicians should also be eligible to receive reporting points for reporting on multi-category measures.

- We once again urge CMS to revise the benchmark methodology and the decile approach for scoring measures, as well as align the methodologies between MIPS and Physician Compare Star Ratings programs.

- We urge CMS to work with specialty societies to develop additional episode-based cost measures to immediately provide more Quality Payment Program (QPP) and claims data to help stakeholders identify MVP opportunities. This would also reduce the costs of developing and proposing cost measures to CMS. CMS should also support smaller specialties by funding measure development.

1. <u>Subgroup Reporting Option under Consideration for MVPs</u>

The AMA reiterates our support for operationalizing a subgroup reporting option that would facilitate participation in MVP by specialists who may be practicing within multispecialty groups. Currently, a clinician must choose to report MIPS data individually or through the group, which includes all MIPS

eligible clinicians within a TIN. The AMA has heard from physicians who are part of a group practice that would like to report separately from the larger group and instead partner with their colleagues in the same or similar specialty. We support allowing an option for a portion of a group to report as a separate subgroup for purposes of MVP or traditional MIPS. This would allow a specialty in a multispecialty group to form a subgroup to report on MVPs that are more clinically relevant to that particular specialty.

We understand CMS faces challenges in implementing a subgroup level reporting option in MIPS. To ease the transition, CMS should consider offering this option in MVP before expanding to the traditional MIPS program. Because MVPs will be built around an episode of care or condition and most likely involve reporting via a registry or Qualified Clinical Data Registries (QCDR), multispecialty groups will find it challenging to engage in MVP unless members of the group are able to form subgroups based on their combined interest in participation in an MVP track. Many MIPS-eligible physicians are part of a multispecialty group and, based on 2018 QPP Experience Report, 53 percent of eligible clinicians received their final score based on participation in a group. For these reasons, we believe an option to report at the subgroup level will be key to the success of MVP.

Subgroup Identification and Election Process

CMS question: Given the desire to identify the NPIs at a single point in time, which option is more important to you?

- Option 1: having additional time to submit the identification information for subgroups even though subgroups would be assessed on less information from the subgroup; or:

- Option 2: submitting the subgroup identification information by July 1 and then being assessed on more information from the subgroup.

AMA response: We understand CMS' desire to identify NPIs at a single point in time for purposes of identifying physicians and clinicians who opt-in to a subgroup for purposes of MVP. The AMA encourages CMS to align the MVP registration process with the subgroup reporting registration process to streamline both elections and minimize administrative burden. We believe clinicians may need greater flexibility in the initial years of MVP to identify the appropriate members of a subgroup and form the subgroup. Therefore, at the outset, we believe the advantages of allowing more time to form a subgroup in option 1 may outweigh its disadvantages. However, we request clarification about the approval of a subgroup. If a subgroup elects to submit their data as a subgroup during the data submission window, will the subgroup need to wait for approval prior to submitting their data? We urge CMS to expedite any approval of subgroups. We also urge CMS to tailor a subgroup's data submission requirements according to their MVP participation. For example, CMS should automatically award IA credit for participation in an MVP. Because this is a brand-new option in MIPS, we urge CMS to revisit the subgroup election process after the first implementation year to determine whether an earlier election process would be preferable.

Regardless of the timing of the subgroup election, we urge CMS to ensure it is a streamlined process, similar to the CMS Web Interface or Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS registration. We do not believe it is necessary to replicate a process as cumbersome as the virtual group agreement process for subgroups interested in MVPs. Subgroups would be members of the same TIN, unlike virtual groups which may be comprised of different groups (with different TINs)

coming together to form an agreement to jointly participate in MIPS. We believe this distinction, between sub-TIN versus multiple-TIN, is important and do not think CMS would need to establish a formal contractual process for members of the same TIN.

CMS question: What are the practical implications to consider if clinicians were to join or leave a subgroup after the subgroup identification period?

AMA response: We appreciate that CMS is considering the impact of the shift in physician practice arrangements. We know the COVID-19 pandemic has put significant financial pressures on physician practices, and we have heard that some physicians are selling their practices. In July and August 2020, the AMA surveyed 3,500 physicians who provided at least 20 hours of patient care per week prior to the pandemic.[1] A strong majority (81%) of surveyed physicians said revenue was still lower than pre-pandemic, with an average drop in revenue of 32%. Compounding the financial stress of lost revenue, practices are also incurring additional costs for heightened infection control protocols and personal protective equipment (PPE).

As mentioned in response to the previous question, we believe the flexibility offered by option 1 is preferable at the outset of the MVP implementation. Physicians who aim to participate in an MVP will need time to get buy-in from colleagues to participate in an MVP, will need to make a business case to the group practice about the benefits of participating in an MVP given the increased resources necessary, and may need to establish new workflows and engage additional vendors to be successful in the MVP. For these reasons, we believe MVP and subgroup election should take place simultaneously during the data submission window. CMS should revisit the timing of the election after MVPs are implemented and make any necessary adjustments.

CMS question: As MVPs are created to be more meaningful to the care eligible clinicians provide and to generate more meaningful information for patients, how should we incentivize the continuation of team-based care within practices?

AMA response: This question frames MVPs and subgroup reporting too narrowly. MVPs and subgroup reporting may be inherently team-based depending on the clinical focus of the MVP and the subgroup reporting arrangement. We have heard interest among specialty societies in working collaboratively on cross-specialty MVPs. CMS should not limit the subgroup option to physicians and clinicians in the same specialty. Rather, CMS should allow physicians to determine the most appropriate participant mix for the subgroup and MVP.

<u>Subgroup Reporting</u>

CMS questions: If CMS allows subgroup reporting, what are some of the modifications third-party intermediaries and practices would have to make in order to allow reporting of MVPs for submitted quality measures and improvement activities for a subset of the NPIs within a TIN? Do third-party intermediaries and practices believe they can manage supporting subgroup reporting over the short and/or long-term? What type of modifications does CMS need to make to our technical specifications to accept data? Would these modifications be so onerous to overcome that third-party intermediaries do not think

[1] American Medical Association, COVID-19 Physician Practice Financial Impact Survey Results, Available at: https://www.ama-assn.org/practice-management/sustainability/covid-19-physician-practice-financial-impact-survey-results.

they can do this? Should we add subgroup reporting to the Certified EHR Technology (CEHRT) requirements? What are the circumstances, if any, where subgroup-level data would be available now to allow for subgroups to be assessed on the Promoting Interoperability performance category? If this information is available, should we work on accepting this data?

AMA response: CMS has an established process for physicians to report electronic clinical quality measure (eCQM) information to CMS. The Quality Reporting Document Architecture (QRDA) is a Health Level 7(HL7) standard used for electronically sharing quality measure data. QRDA documents are often generated by EHRs. CMS modifies HL7's guidance to create a specific CMS "form and manner" version of the QRDA used for MIPS participation. ONC's newly updated certification program requires that certified EHR technology must meet CMS' specific requirements for federal reporting program participation.

HL7's QRDA supports NPI and TIN information in the base standard. CMS' specific requirements further constrain the use of NPI and TIN in several ways. Modifications may need to be made to HL7's base standard in order to support new NPI/TIN combinations and subgroup identifiers. This may necessitate changes to CMS' specific QRDA requirements. If CMS allows for subgroup reporting, it will need to take into account the time for HL7 to update its base standard—including public commenting, balloting, and testing the new implementation guidance. At that point CMS will then be able to modify its specific QRDA requirements. For instance, new subgroup identifiers and mechanisms to identify the NPIs in the subgroup will need to be supported by corresponding HL7 registered object identifiers (OIDs). Furthermore, QRDA documents are used to support Promoting Interoperability (PI) reporting. Changes to HL7's base standard and CMS' specific guidance will also need to account for subgroup-level PI reporting attribution. Additionally, third-party intermediaries will need time to adopt and test their systems to support any QRDA updates. This may include mapping internal systems to new subgroup elements and adjusting processes used by intermediaries for reporting MVP/MIPS performance categories on behalf of physicians.

From the physician/medical practice end user perspective, EHR vendors will need to adopt new process and workflows for QRDA generation and reporting. Currently, NPI and TIN information is often pre-populated in the QRDA based on information already recorded in the EHR. However, EHR vendors advise that physicians should ensure that their appropriate individual NPI number is recorded accurately, often requiring medical practices to enter a workflow for editing eCQM dashboard groups. Physicians are also required to select or confirm the quality measures to be included in the QRDA file report. With the addition of a new subgroup identifier, EHRs will need to support a process for physicians to self-select subgroup membership, track unique users across PI, Quality, and IA performance categories, develop new MVP/MIPS dashboards, and account for changes to subgroup rosters when physicians leave or join subgroups.

We believe CMS should also consider the following issues:

- How will CMS' website validate QRDA submissions and support physician practice troubleshooting under MVP subgroups?

- Will CMS support practitioner rosters to help match new subgroup identifiers? Will CMS develop a process to manage subgroup identifiers in the same way that the National Plan and Provider Enumeration System supports the NPI?

- How will modifications to HL7's base QRDA standard and CMS' specific QRDA requirements impact ONC's certification process for the "CQMs – report" criterion in §170.315(c)(3)? CMS will need to align subgroup reporting with ONC's 2015 Cures Update requirements.

- The timing required to update third-party intermediary systems, such as EHRs to support subgroup reporting.

Subgroup Scoring

CMS question: Should subgroups receive their own final score or have their subgroup score rolled into the group's final score? Are there alternate options that we should consider for appropriately scoring subgroups?

AMA response: The AMA urges CMS to allow group practices the option to have their subgroup score rolled into the group's final score or to have the subgroup receive their own final score. Many stakeholders at the MVP Town Hall expressed concerns about the complexity of managing multiple physicians and eligible clinicians within a TIN getting paid different Medicare amounts for the same services. On the other hand, we heard support for allowing subgroups to receive a separate score to incentivize participation at the subgroup level. Therefore, we urge CMS to give group practices the choice of having separate scores for subgroups or rolling their subgroup score into the group's final score. We also agree with comments made at the Town Hall that support subgroups receiving the higher of their score or the group practice score.

In addition, physicians in the group who are not affiliated with the subgroup that is participating in an MVP should retain the option to participate as a group practice in traditional MIPS or select another MVP. We urge the agency to look to its "split-TIN" policy for certain Advanced APMs, where some of the clinicians billing under the group's TIN participate in the model while others do not. In this case, the portion of the group that is not participating in the model has the option to participate in MIPS as a split-TIN and can register for the CMS Web Interface or report via another data submission mechanism. This will minimize the burden on multispecialty groups who have a subgroup interested in an MVP.

Future of Subgroups

CMS question: Should subgroup reporting ever be mandatory?

AMA response: The AMA strongly opposes making subgroup reporting or participation in an MVP mandatory. The AMA also does not support requiring participation in an MVP at the subgroup level. Clinicians who are interested in participation in an MVP should have the choice to participate as individual clinicians, as a subgroup, as a virtual group, or as a group.

Mandatory nationwide implementation is often fraught with problems. There is a learning curve for any new program and initiatives need to be sufficiently flexible to make mid-course corrections.

CMS question: What can we do to make the increased burden reasonable?

AMA response: While we have heard support for subgroup reporting from physicians and specialty societies, we acknowledge that large group practices would face trade-offs with this option. Depending on

how MVP is structured, it could potentially mean reporting the same information multiple times, which will create additional administrative burden. If CMS develops a meaningful MVP program that is appropriately tailored to physician's specialty and site of service then doctors will not find subgroup reporting burdensome. There is good evidence that shows that physicians respond to real-time high-quality data feedback due to intrinsic motivation. A study published in the American Economic Review shows that "information on performance that was new to surgeons and unrelated to patient demand led to an intrinsic response four times larger than a surgeon's response to a profit incentive."[2]

A physician with little information on his own performance, and that of his peers, is unable to accurately observe both static levels of quality and improvements. This increased uncertainty reduces the intrinsic motivation for quality improvement due to the physician unable to see the results of efforts or may believe, due to a dearth of information that they are performing on satisfactory levels.

The AMA has made numerous suggestions to create a less burdensome, more streamlined option for subgroups in MVP. We believe CMS must implement these suggestions to incentivize reporting at the subgroup level. Our recommendations include making MVP voluntary, establishing a point floor, requiring fewer quality measures, piloting testing, flexibility by allowing attestation for PI, and receiving automatic credit in the IA category.

CMS should also offer flexibility for single specialty groups with sub-specialists. For instance, if there were an MVP for cataract surgery, and all the cataract surgeons in the group worked together on it, the other physicians who do not perform cataract surgery, such as retina specialists, would likely have to start reporting on primary care measures because they do not have enough ophthalmic measures in MIPS.

2. MVP Overview

Value of MVPs to Patients

CMS question: What additional steps should CMS consider in making MVPs more impactful to patients and to better integrate the voice of patients?

AMA response: The AMA is concerned with CMS' continued emphasis that MVPS must include population health administrative claims measures as a foundation to MVPs. Population health measures move the MVP away from incorporating the patient's voice, measuring clinical conditions and outcomes, and generating real-time feedback. Assessing physicians on broad measures and that do not differentiate care among specialties does not lead to improved patient care or for purposes of public reporting lead to providing useful information about care. For instance, measuring all physicians on All-Cause Readmission (ACR) and comparing an orthopedic surgeon to a primary care physician on the same measure does not provide a patent any meaningful information or assistant the patient in determining the most appropriate physician to treat them for a particular condition. As another example, the Total Per Capita Cost (TPCC) measure looks at average cost from the payer perspective and attributes many costs that are outside the control of the patient's physician. This measure is not helpful from the perspective of a patient who is interested in comparing the costs for a procedure or primary care. Worse, TPCC is not aligned with existing quality measures in MIPS and could be misleading or confusing to patients who are interested in the highest value care.

[2] Kolstad, Jonathan T. 2013. "Information and Quality When Motivation Is Intrinsic: Evidence from Surgeon Report Cards." *American Economic Review*, 103 (7): 2875-2910.

CMS must address the lack of alignment of the attribution models utilized for the various administrative claims measures used for the MIPS population health measures (or future consideration) and costs measures, such as Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR), Multiple Chronic Condition (MCC) and TPCC. Based on the proposed changes to attribution in many of these measures to hold more than one physician accountable and/or leverage different approaches (e.g., plurality of charges vs. plurality of visits), physicians and practices will have different patients assigned to them for different measures. This lack of consistency across measures will further decrease a physician's ability to drive improvements in care. The lack of a cohesive approach on attribution across one program is not sustainable and must be addressed to create a system that promotes and facilitates improvements to patients in a way that is also meaningful and actionable by physicians.

Furthermore, we continue to urge CMS to revise the MIPS benchmark methodology and align the methodologies between MIPS and Physician Compare Star Ratings. Through our examination of the two programs, we found that the two methodologies (MIPS and 5-star) resulted in inconsistent ratings and comparisons. In several instances, physicians deemed to be of similar quality by one methodology were classified as having different levels of quality by the other methodology. Additionally, some physicians classified in the highest (or lowest) level of quality by one methodology were not classified as such by the other methodology. The fact that the two methodologies produce different results when rating and ranking the same physicians implies that at least one of the methodologies is lacking and suggests that further thought and testing is necessary. As a result of the inconsistencies, it is leading to further physician frustration and dissatisfaction and lack of confidence in the MIPS program. Further, these inconsistencies send mixed signals to patients who might make incorrect assumptions about physician quality when deciding where to seek care.

MVP Alignment with APMs

CMS question: We believe that a grouping concept, such as categorizing MVPs based on if there is a corresponding APM or not, can help us clearly articulate how MVPs can help reduce barriers to APMs. How could this concept be utilized to help facilitate movement to MVPs? How could the grouping concept be helpful to stakeholders who are developing MVPs? What other criteria could we consider as part of these groups? For example, should we categorize MVPs based on if they are procedure based or episode-based MVPs compared to population-based MVPs?

AMA response: The AMA believes it is too early to develop a categorization system for MVPs as CMS has yet to propose the first MVP. We urge CMS to better explain its rationale for this grouping concept. How would labeling an MVP as a population-based MVP as opposed to an episode-based MVP help reduce barriers to APMs?

CMS question: Should CMS prioritize development of MVPs in areas where an APM exists or in areas where APMs do not exist to fill in gaps?

AMA response: The AMA urges CMS to develop MVPs so they can serve as both a long-running performance-based option to improve physicians' experience in MIPS and as a steppingstone for clinicians between participation in separate, unrelated MIPS measures and participation in an APM or Advanced APM. Maintaining MVP as a long-running, performance-based option in MIPS will be especially important for small practices, who face more challenges in MIPS and have lower mean and median MIPS scores than rural and large practices. However, they do not have a sufficient number of patients or financial capital to invest and participate in an Advanced APM.

CMS question: In the CY 2020 PFS proposed rule, we solicited feedback on ways to reduce barriers to APM participation and generally heard from commenters that barriers could be reduced by providing more robust performance feedback, increase APM availability, streamline reporting by MVPs to MIPS, increase risk experience, and offer risk education (84 FR 40732). What elements of APM design might we consider in developing MVPs (e.g., similar measures or activities) that would make clinicians feel more confident in making the decision to continue moving towards value in an APM? Are there additional tools that CMS could provide to help clinicians further prepare to take on more risks? Is there anything more that CMS needs to provide (i.e., access to more data)?

AMA response: The AMA recommends that CMS take several steps to reduce barriers between MIPS and APMs, including:

- By holding clinicians accountable for quality, cost, health IT use, and improvement activities tied to a specific condition, procedural episode, or public health priority, MVP participation could help clinicians control or reduce Medicare spending while also improving quality. The approach would allow physicians to better focus their improvement efforts as opposed to the current approach of broadly focusing on quality with no clear connection to a health outcome. It would also enable specialists to participate more effectively in larger APMs, such as ACOs.

- CMS should also consider MVP proposals that include more flexibility to improve value for the patient population. For example, the specialty society or other stakeholder group proposing that management of a condition be eligible for the MVP track of MIPS could propose certain payment changes to support improvements needed to care for this condition, such as paying for Collaborative Care to help support team-based approaches to managing patient care. Although MVP clinicians would not be subject to the two-sided risk requirements of Advanced APMs, the MIPS measures of cost and quality for the episode and MIPS payment adjustments will serve to hold them accountable in a similar manner to APM participants.

- As a feature of MVPs, CMS should also provide claims and QPP data to the participating practices. This is something that CMS does for other APMs and, in some cases, an important advantage of participation in APMs. Providing claims data analysis would help MVP participants to improve care and reduce costs, while also enabling them to design effective APMs. CMS could also partner with its Technical Support contractors to assist physicians with accessing and reviewing claims data.

- The AMA reiterates our substantial concerns with CMS' decision to eliminate the MIPS APM Scoring Standard and transition all MIPS APM quality measures to the APP measure set. It is unclear how CMS determined that the APP measures are more appropriate than the current measures APMs are evaluated on. The one size fits all approach does not take into consideration the spectrum and variability between the MIPS APM programs or create a set of measures that better inform patients. Many important measurement areas are not captured, such as patient safety. For example, it does not make clinical sense for Bundled Payments for Care Improvement Advanced, or BPCI-A, to be compared and measured on the same set of measures that apply to Comprehensive Primary Care Plus (CPC+) participants. However, it would potentially make sense to utilize the same measure set for CPC+ and Primary Care First (PCF) model participants since they are both primary care focused programs. Quality measurement within APM programs must focus on measures most appropriate to the program and ensure holding organizations accountable for cost does not lead to stinting on care. Therefore, the quality measures must match the goals of the APM.

Additionally, we are concerned that the APP is contrary to CMS' goals that MIPS APMs serve as a bridge between traditional MIPS and Advanced APMs. Unlike the MIPS APM scoring standard, the APP is not a hybrid of MIPS and APMs because the quality measures are no longer tailored to the APM. Although the MIPS APM participants are already focused on the aligned cost and quality measures of the APM, they must now add an additional layer of quality measure reporting, solely for purposes of the APP. We are especially concerned that CMS sees parallels between the APP and MVPs and strongly urge CMS to prioritize the goal of creating a bridge between traditional MIPS and Advanced APMs for both MIPS APMs and MVPs by aligning the MIPS and APM measures to the extent possible rather than creating a one-size-fits-all approach.

CMS question: What, if any, are the scenarios where similar APM and MVP topics should utilize different measures? For example, should a cancer care MVP have similar measures to the Oncology Care Model? Would practices performing on these measures in MIPS make practices feel more confident about joining an APM with similar measures in the future?

AMA response: There may be scenarios where it would be impractical and unfair to use the same measures in an MVP and Advanced APM. For example, Advanced APM participants can take advantage of waivers of certain fraud and abuse regulations and some receive per beneficiary per month payments, which allow APM participants to invest in greater care coordination through hiring a nurse care navigator as an example. These waivers and financial capital are not available to MIPS clinicians and may hamstring their ability to meet the same measures as Advanced APM participants. We urge CMS to work collaboratively with national medical specialty societies to determine the appropriate measures and activities for an MVP.

CMS question: How do we ensure that MVPs are meaningful to specialty clinicians that have limited applicable APM models available to them?

AMA response: The AMA urges CMS to develop MVPs so they can serve as both a long-running performance-based option to improve physicians' experience in MIPS and as a steppingstone for clinicians between participation in separate, unrelated MIPS measures and participation in an APM or Advanced APM. Maintaining MVP as a long-running, performance-based option in MIPS will be especially important for small practices, who face more challenges in MIPS and have lower mean and median MIPS scores than rural and large practices. However, they do not have a sufficient number of patients or financial capital to invest and participate in an Advanced APM.

<u>MVP Participation</u>

CMS question: We are planning to retire traditional MIPS in a future state but recognize that due to the COVID-19 public health emergency, clinicians may be at different stages of readiness to move to MVP reporting. How has the PHE impacted clinicians' ability to move along the continuum of value, increasing the quality of care provided while taking on greater financial risk? In thinking towards the future, what criteria should be met before traditional MIPS is retired? Should there be a certain threshold of MVPs which are available and applicable for eligible clinicians to report before traditional MIPS is retired?

AMA response: **The AMA does not support retiring traditional MIPS.** In a sign-on letter to CMS sent in April 2020, the AMA joined 37 national medical specialty societies in strongly urging CMS to

make MVP participation voluntary and to incentivize physicians to opt-in to MVPs.[3] **Physicians should have the choice to opt-in to participate in an applicable MVP, if available, or remain in traditional MIPS.** CMS should notify physicians of an applicable MVP through multiple avenues, including the QPP Participation Status Tool, QPP submission portal, and the QPP performance feedback reports. CMS should base its MVP suggestions for each physician and group practice on a combination of past MIPS reporting data, physician specialty designation, and claims data.

The AMA agrees with CMS that the COVID-19 public health emergency has placed significant financial pressure on physician practices. In July and August 2020, the AMA surveyed 3,500 physicians who provided at least 20 hours of patient care per week prior to the pandemic.[4] A strong majority (81%) of surveyed physicians said revenue was still lower than pre-pandemic, with an average drop in revenue of 32%. Compounding the financial stress of lost revenue, practices are also incurring additional costs for heightened infection control protocols and PPE.

The AMA continues to be strongly supportive of the option for physicians to be held harmless under the Extreme and Uncontrollable Circumstances Hardship Exception due to COVID-19. We urge CMS to consider the financial distress and long road to recovery for physician practices and to gradually phase-in MVPs, allowing for a transition period so physicians who opt into MVPs are not unfairly penalized in the pathway's infancy.

Clinician Choice of MVPs

CMS question: We have received requests from stakeholders to guarantee that MVP reporters receive at least a neutral or positive payment adjustment under MIPS, without the potential to receive a negative payment adjustment. We note that this is not possible under the MIPS statute and we must maintain assessment under the four performance categories and a composite score. Since reporting MVPs is voluntary, how would you suggest encouraging participation in MVPs over traditional MIPS reporting? How can CMS help clinicians, groups, or third-party intermediaries overcome barriers to be able to report an MVP?

AMA response: The intent of MVP is to provide a more holistic QPP program. Therefore, we urge CMS to allow MVP participants to attest to PI and provide automatic full credit in IA, which will greatly incentive physicians to participate in MVP and move away from traditional MIPS.

CMS question: Clinicians and groups expressed concern about the operational burden associated with transitioning to MVPs from MIPS. How can we minimize these operational challenges as we implement MVPs? We have heard from stakeholders that clinicians do not want to be assigned to an MVP. If MVPs are optional, how do we make sure that clinicians are choosing appropriate MVPs to report? For example, should CMS assume that a clinician electing an MVP would be able to report on all measures and activities within a given MVP, a minimum number of measures or activities, or at least one measure or activity from the quality, cost, and improvement activities performance category (recognizing that the

[3] Sign-on Letter to CMS, April 10, 2020, Available at: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2FSign-on-letter-to-CMS-on-MVP-04-10-20.pdf

[4] American Medical Association, COVID-19 Physician Practice Financial Impact Survey Results, Available at: https://www.ama-assn.org/practice-management/sustainability/covid-19-physician-practice-financial-impact-survey-results.

Promoting Interoperability performance category is required no matter the MVP)? What kind of information can CMS provide to help facilitate the choice?

AMA response: **Physicians should have the choice to opt-in to participate in an applicable MVP, if available, or remain in traditional MIPS.** CMS should notify physicians of an applicable MVP through multiple avenues, including the QPP Participation Status Tool, QPP submission portal, and the QPP performance feedback reports. CMS should base its MVP suggestions for each physician and group practice on a combination of past MIPS reporting data, physician specialty designation, and claims data. CMS should reduce the reporting burden in MVPs through requiring fewer measures and allowing physicians to receive credit in multiple categories for aligned quality improvement efforts and improvement activities or promoting interoperability or both. CMS should retain flexibilities for non-patient-facing and other clinicians who may be unable to report or be scored on certain measures due to small case sizes and limited applicable measures in certain categories, such as Promoting Interoperability.

3. MVP Reporting and Scoring

MVP Reporting Requirements

CMS questions: We have heard from stakeholders that clinicians want the ability to select measures and activities within an MVP. If clinicians have the choice to select measures and activities in an MVP, how do we ensure that a clinician elects an appropriate MVP? Is it reasonable for CMS to assume that a clinician electing an MVP will report on a minimum number of measures or activities for cost, quality, and improvement activities (recognizing that the Promoting Interoperability is included in the foundational layer for all MVPs and thus will also be reported)? If not, what are the alternative assumptions CMS should be working under? We've heard clearly that clinicians and groups want choice yet want the program to be simple. Are there other ways we can maintain a degree of flexibility while achieving greater simplicity through the MVP reporting option?

AMA response: The best way to ensure simplicity is to not require reporting on a certain number of minimum measures, type or focus of measures (outcome, process, etc.) and assign varying weights. CMS has tried over the years to similarly structure the physician programs and that has resulted in an administratively burdensome program and regular complaint of reporting for the sake of reporting.

In terms of relevancy, physicians are in the best position to determine which clinical area will be most meaningful to their practice, and it may be many years before MVPs exist for the majority of physician subspecialties and practice arrangements. Determining the most appropriate MVP and reporting on a suite of measures or menu is dependent on the structure of the MVP. For example, if an MVP is broadly focused on oncology and includes measures that address both breast and prostate cancer than there needs to be measure choice given there is sub-specialization within oncology. It is more than likely that different specialties within oncology treat a breast cancer patient and prostate cancer patient. If the MVP was focused on geriatric surgery in the inpatient setting, depending on the measures within the MVP it may be broadly applicable to the various surgical specialties that perform a high volume of surgery in the inpatient setting and measure choice may not be necessary.

Measure Objectives within the Quality Performance Category

CMS questions:

- We noted an example above to illustrate how the objectives within the quality performance category could be weighted. How should the objectives within the quality performance category be weighted? Do the objectives we are considering adequately address MIPS priorities? Are there other objectives we should consider including instead?

- Should we allow objectives to be reweighted if a clinician does not have sufficient case volume to report? Should we require that clinicians report on a minimum number of measures in the objectives, "Improve Care Relevant to Clinician Specialty" and "Incorporating Patient Voice." Should measures have a different number of available measure points similar to how the Promoting Interoperability performance category works?

- We anticipate there may be a time when we require reporting, such as a measure related to a public health issue, by everyone who reports the MVP. What kinds of measures should be required for MVP reporting?

AMA response: Depending on the structure and focus of an MVP, we would not oppose the lack of ability to choose measures within an MVP as long as the MVP is structured in such a way that lack of choice would not penalize a physician if they did not have denominator eligible patients or measures that are relevant to their scope of practice. For instance, requiring all ophthalmologists to report on a cataract MVP and all associated measures would be problematic because not all ophthalmologists perform cataract surgery. Within ophthalmology and among many other physician specialties there is sub-specialization. However, if there were additional MVPs that addressed the relevant scope of practice of other sub-specialists within the specialty then lack of choice would not be such an issue.

The current example CMS provides on the structure of the quality category appears extremely similar to the existing MIPS specialty measure sets and the intent of the specialty measure sets was to act as a guide to assist with choosing relevant measures within MIPS, not form a structure of a program or category within MIPS. Therefore, the example does not move the program to a more holistic approach to measuring quality. The thinking is still very individualistic, as opposed to moving the program to be more episodic or clinically focused with a clear end goal of the desired outcome. As the AMA has repeatedly highlighted in comments and conversations with CMS on MVP, the number of measures within an MVP should be determined by the MVP steward based on what is most appropriate to measure the clinical focus of the MVP and improve patient care.

We also would not support a scoring policy that assigned quality measures different weights based on the priority area or focus of the measure like the way the IA category is currently structured. Assigning weights to measures is extremely subjective, confusing and administratively burdensome.

Furthermore, the AMA is concerned with CMS' continued emphasis that MVPs must include population health administrative claims measures as a foundational layer. We do not believe organizations will develop MVPs if CMS moves forward to require population health administrative claim measures. Population health measures also move the MVP away from incorporating the patient's voice, measuring clinical conditions and outcomes, and generating real-time feedback.

Over time, measure developers have moved away from administrative claims measures due to concerns over attribution, retrospective analysis, the inability to measure individual physicians, and outcomes. Organizations have shifted to the development of electronic Clinical Quality Measures (eCQMs) and QCDRs due to the shortcomings with administrative claims measures, including the inability to move to clinically meaningful outcome measures. QCDRs and eCQMs electronic tools provide for a much richer data source than administrative claims measures. For example, it is very difficult to get to intermediate outcomes, such as diabetes HbA1c levels or blood pressure level measures, without requiring additional data collection. Therefore, CMS will be left to select measures that may be sufficient from the community or population perspective but are not appropriate to attribute to an individual physician or practices. If this happens and the measures are so far removed from clinical practice, the measure will not provide meaningful or actionable data at the point of care.

We also do not believe CMS considered that implementation of population health measures will further diminish the viability of small practices. Most of the promising strategies related to addressing population health, such as hiring nurse coordinators may be a violation of the Stark and Anti-Kickback statutes. Therefore, the only way to work around the statute is to become employed by a hospital. Individual and small practices also do not typically have a large enough patient sample size to calculate a reliable score. President-elect Biden has expressed his concern about the consolidation in health care. The AMA believes that if CMS continues to rely on population health measures it will accelerate the consolidation of the health care market.

MVP Reporting Example

CMS question: Are there any concerns we should take into consideration on including only a subset of improvement activities (as compared with the full inventory of improvement activities)?

AMA response: The specialty society developing the MVP is best suited to determine the most appropriate IAs that match the focus of the MVP. We can find no rationale to support CMS limiting the range of IAs that may be included in an MVP and recommend that the agency make the full inventory available to those developing MVPs.

CMS question: We anticipate that it will take some time to identify or develop applicable cost measures for all clinician/specialty types. What do we do in the interim for MVPs in which clinicians do not have an applicable cost measure?

AMA response: The AMA understands that CMS is currently soliciting public comments about potential measure concepts for future episode-based cost measures, and we appreciate the collaborative process CMS has established for developing these cost measures. We believe there are opportunities to help fill gaps and develop a robust menu of episode-based cost measures by working with the specialty societies to identify, develop, and/or test new measure concepts. Specialty societies may be at various stages of development of cost measures. For instance, some may have given it significant thought for purposes of a Physician-Focused Payment Model (PFPM) submitted to the PFPM Technical Advisory Committee (PTAC). However, specialties have informed the AMA that they have not had sufficient access to claims data to analyze costs. **We urge CMS to immediately provide more QPP and claims data to help stakeholders identify MVP opportunities and reduce the costs of developing and proposing them to CMS. CMS should also support smaller specialties by funding measure development.** As ongoing work continues, CMS should allow MVPs to reweight the cost category to

zero due to the lack of data and appropriate measures and provide physicians with improved cost measure feedback.

MVP Scoring

CMS question: In the absence of bonuses, are there adjustments we need to make within traditional MIPS or MVPs to facilitate equitable scoring?

AMA response: We are concerned that few physicians will choose MVP as the possibility of failure and a potential 9% Medicare penalty may be a serious barrier to overcome. CMS should design MVP scoring to address this concern. To further reduce complexity and allow physicians to better predict how they will perform under MIPS, we recommend that CMS move to reporting points in the quality and cost category and attestation-based scoring in PI and IA. For instance, in the quality and cost categories physicians would receive a set number of reporting or attribution points, such as five points for being attributed or reporting on each measure, plus additional points (up to five) based on their performance against the measure benchmark. They also could be eligible to receive reporting points for reporting on multi-category measures. IA scoring would continue to be attestation-based, but all activities would be weighted equally, such as each IA worth 10 points. PI measures would each be worth 10 points for attesting to having at least one patient in the numerator. This higher point value is warranted as health IT is a significant investment for physician practices and needs to be continually updated, and as CMS has noted, the use of health IT can help with practice and quality improvement to result in better patient health outcomes. **Please see the Appendix for an illustrative example of how multi-category credit scoring will work for MVPs compared to traditional MIPS.**

We once again advocate and urge CMS to revise the benchmark methodology and decile approach for scoring measures, as well as align the methodologies between MIPS and Physician Compare star ratings programs. We urge CMS to incorporate more of a manual driven approach which will allow for less clustering of data. A revised methodology will better allow CMS to handle random fluctuation in numbers due to small sample sizes, topped-out measures, better incorporate clinical knowledge, and move to one scoring methodology for MIPS and Physician Compare.

MIPS awards points to physicians based on their performance relative to decile-based categories calculated from historical data (when available), while Physician Compare Star Ratings use a five-point rating system. Therefore, our main concerns with the MIPS benchmark methodology are:

1. For topped-out or highly skewed data, thresholds are clustered close together (meaning that similar performance may not result in similar points awarded) and even relatively high performance can place a physician in one of the lower deciles. For example, a physician could score 88 percent and be in the 4th decile while another physician scores 92 percent and is in the 8th decile. Therefore, on the same measure two physicians can perform very similarly on the measure but may be awarded very different points;

2. There is a lack of consideration of the role played by random fluctuation, especially for small denominators;

3. Strictly data-driven thresholds may conflict with clinical knowledge and evidence of ideal performance or with practical considerations of quality;

4. There may be significant changes to the population of physicians and groups between the time that the historical data represents (2 years prior) to the time period to which the resulting thresholds are applied; and

5. Under certain circumstances, physician performance score under MIPS may differ significantly from their performance under the Physician Compare methodology, even for the same measure.

We urge CMS to revise the benchmark methodologies to allow measure thresholds to incorporate clinical knowledge and evidence, consider the impact of random fluctuation, and be adjusted for practical considerations of comparison and relative performance. To address the shortcomings of the existing benchmark methodologies, we suggest that CMS implement a methodology that allows for manual manipulation of thresholds. These adjustments would allow for enough flexibility to address the above issues when they arose. We acknowledge that this would add process to an already complex method, but we believe that what is most important is ensuring the fairness and clinical relevance of the measured benchmarks. We further acknowledge that there may be modifications to the methodology other than what we suggest which may also address our concerns and welcome the opportunity to discuss further with CMS. Please see AMA's 2020 Physician Fee Schedule/Quality Payment Program Proposed Rule Comments for more detailed analysis and recommendations on the issue.

CMS question: Are there any scenarios where we should consider reweighting the cost performance category for clinicians who do not meet the case minimum for cost measures included in the MVP? If not, should we require that clinicians report a different MVP or traditional MIPS?

AMA response: If a clinician, subgroup, or group does not meet the case minimum for a cost measure, the measure should not be scored. The minimum case thresholds should be set at the level needed for reliability and CMS should accept the fact that this will lead to fewer clinicians being attributed the measure.

As mentioned in response to the previous question, to fill the gaps particularly for specialties that are not attributed an existing cost measure in MIPS, we urge CMS to work with specialty societies to develop additional episode-based cost measures. Specialty societies may be at various stages of development of cost measures. For instance, some may have given it significant thought for purposes of a Physician-Focused Payment Model (PFPM) submitted to the PFPM Technical Advisory Committee (PTAC). However, specialties have informed the AMA that they have not had sufficient access to claims data to analyze costs. **We urge CMS to immediately provide more QPP and claims data to help stakeholders identify MVP opportunities and reduce the costs of developing and proposing them to CMS. CMS should also support smaller specialties by funding measure development.** As ongoing work continues, CMS should allow MVPs to reweight the cost category to zero due to the lack of data and appropriate measures and provide physicians with improved cost measure feedback.

Thank you for your consideration of these comments. If you would like to further discuss this matter, please contact Margaret Garikes, Vice President for Federal Affairs, at Margaret.garikes@ama-assn.org.

Sincerely,

James L. Madara, MD

APPENDIX
MIPS Value Pathways (MVPs):
Illustrative Comparison of Traditional MIPS and MVP Scoring Approaches

The comparison tables below illustrate an MVP scoring approach that incorporates a multi-category scoring framework to reduce reporting burden, incentivize physicians and eligible clinicians (ECs) to opt-in to an MVP, and focus on a condition, episode of care, or public health priority. This example pulls from the AMA's Diabetes Prevention MVP.

The AMA continues to hear from specialty societies that a one-size-fits-all scoring approach will not work for MVPs. CMS should apply the special scoring rules in MIPS to MVPs.

Differences in this example between Traditional MIPS and MVP scoring approaches:

- MVP participants receive multi-category credit in both the Quality and Improvement Activity Performance Categories for an aligned measure/activity.
- MVP participants receive multi-category credit for both the Quality and Promoting Interoperability Performance Categories for use of end-to-end electronic reporting.
- MVP participants receive a bonus of up to the equivalent of the performance threshold to hold ECs harmless from a penalty in the first year that the MVP is available to physicians. As MVPs will be implemented on a rolling basis, the bonus should apply in the first year that each new MVP becomes available as an option for ECs.
- Due to the lack of appropriate and applicable cost measures to measure the cost savings of prevention, the AMA welcomes the opportunity to collaborate with CMS to develop a cost savings proxy measure until the agency develops a prediabetes episode-based cost measure.

Similarities in this example between Traditional MIPS and MVP scoring approaches:

- Category weights and reweighting policies are consistent.
- All scoring flexibilities, such as the small practice bonus, are consistent.
- The CMS-defined population health measure, Hospital-wide, 30-day all-cause unplanned readmission rate, is scored as part of the Quality Performance Category.

	MVP Scoring Example – Traditional MIPS Scoring Scenario Diabetes Prevention Measures				MVP Scoring Example – Alternative Scoring Scenario Diabetes Prevention MVP			
	Quality	**Cost**	**Promoting Interoperability**	**Improvement Activities**	**Quality**	**Cost**	**Promoting Interoperability**	**Improvement Activities**
Category Weight	**40%**	**20%**	**25%**	**15%**	**40%**	**20%**	**25%**	**15%**
Screening for Abnormal Blood Glucose (eCQM)*	3-10 points	0	0	0	3-10 points	0	0	50% credit for IA (20 points)
Intervention for Prediabetes (eCQM)	3-10 points	0	0	0	3-10 points	0	0	0
Retesting of Abnormal Blood Glucose in Patients with Prediabetes (eCQM)	3-10 points	0	0	0	3-10 points	0	0	0
Hospital-wide, 30-day all-cause unplanned readmission rate (if ≥200 cases and group ≥16 ECs)	3-10 points	0	0	0	3-10 points	0	0	0
Report quality measures electronically via CEHRT**	3 bonus points	0	0	0	3 bonus points	0	50% credit for PI	0
Small practice bonus (≤15 ECs)	6 bonus points	0	0	0	6 bonus points	0	0	0
Total Per Capita Cost (if ≥20 cases)	0	1-10 points	0	0				
Medicare Spending Per Beneficiary (if ≥35 cases)	0	1-10 points	0	0				
Prediabetes episode-based cost measure					0	1-10 points	0	0

	MVP Scoring Example – Traditional MIPS Scoring Scenario Diabetes Prevention Measures				MVP Scoring Example – Alternative Scoring Scenario Diabetes Prevention MVP			
	Quality	**Cost**	**Promoting Interoperability**	**Improvement Activities**	**Quality**	**Cost**	**Promoting Interoperability**	**Improvement Activities**
or other claims-based proxy								
2015 CEHRT and functionality specifications for prediabetes (ex. use of APIs to monitor patient weight levels)					0	0	50% credit for PI	0
2015 CEHRT attestation measures	0	0	Necessary for any PI credit	0				
PI attestation measures	0	0	Necessary for any PI credit	0	0	0	Necessary for credit in PI	0
e-Prescribing	0	0	1-10 points	0				
Support Electronic Referral Loops by Sending Health Information	0	0	1-10 points	0				
Support Electronic Referral Loops by Receiving and Incorporating Health Information	0	0	1-10 points	0				
Provide Patients Electronic Access to Their Health Information	0	0	1-40 points	0				
Report to two public health agencies or clinical data registries	0	0	0 or 10 points	0				

	MVP Scoring Example – Traditional MIPS Scoring Scenario Diabetes Prevention Measures				MVP Scoring Example – Alternative Scoring Scenario Diabetes Prevention MVP			
	Quality	**Cost**	**Promoting Interoperability**	**Improvement Activities**	**Quality**	**Cost**	**Promoting Interoperability**	**Improvement Activities**
Query PDMP	0	0	5 bonus points	0				
Verify Opioid Treatment Agreement	0	0	5 bonus points	0				
Glycemic Screening Services (medium-weighted)	0	0	0	10 points (or 20 points if small, rural, HPSA, or non-patient-facing)				
Glycemic Referring Services (medium-weighted)	0	0	0	10 points (or 20 points if small, rural, HPSA, or non-patient-facing)	0	0	0	50% credit for IA (20 points)
Complex patient bonus	Up to 5 bonus points				Up to 5 bonus points			
MVP bonus***					Up to the performance threshold (60 points)			

* Multi-category credit for quality and IA for an aligned measure/activity
**Multi-category credit for quality and PI for use of end-to-end electronic reporting
*** Applies in the first year that each new MVP becomes available as an option for ECs.