AMA AMERICAN MEDICAL ASSOCIATION

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June 8, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G 200
Independence Avenue, SW
Washington, DC 20201

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to urge the Centers for Medicare & Medicaid Services (CMS) to prioritize data sharing and transparency in the Merit-based Incentive Payment System (MIPS), particularly the Cost Performance Category. Despite numerous requests and recommendations from the AMA and the national medical specialty societies, physicians do not receive timely, actionable feedback on their resource use and attributed costs in Medicare. Transparency and data access are essential for physicians and national medical specialty societies to identify variations in spending that are not accounted for by differences in patient needs and to eliminate unnecessary costs. While we appreciate CMS for taking a positive step in this direction by responding to our recommendation to release the cost measure benchmarks, we urge CMS to go farther to increase its data sharing and improve the feedback reports and Quality Payment Program (QPP) Experience Reports.

As CMS has increased the weight of the Cost Performance Category to 30 percent of a physician's or group's final score, it is more important than ever to help physicians understand how they are performing in this Category. What is a lower-cost physician doing differently from a high-cost physician? For example, is it that they are better at care coordination? If we don't know the answer, we cannot achieve the goal of reducing avoidable costs and overuse. Access to cost data will only grow in importance as CMS moves forward with MIPS Value Pathways.

1. **Recommendation: CMS should release data about the impact of COVID-19 on MIPS cost measures.**

We acknowledge that MIPS and the Cost Performance Category have been significantly impacted by the COVID-19 public health emergency (PHE) and, as a result, data from the 2020 and 2021 performance periods are limited in relevance and accuracy. We greatly appreciate that CMS zeroed out the Cost Performance Category in those years and that the Agency plans to release patient-level feedback reports to physicians based on the 2021 performance year. Based on our conversation with CMS staff, we also understand that the Agency has access to insightful information about the impact of the COVID-19 PHE on the measures but that there may not be an appetite to share this information with stakeholders. **We urge CMS to release all information that it has related to the impact of COVID-19 on the MIPS cost measures, as this information will help inform physicians and national medical specialty societies about trends in resource utilization that may continue after the PHE ends.** Physicians and

national medical specialty societies are keen to understand the impact of the pandemic by measure, by participation type, by specialty, and by region.

2. **Recommendation: In addition to retroactively publishing cost measure benchmarks, CMS should provide benchmarking and attribution data on a rolling basis during the performance period.**

While we appreciate that CMS has retroactively published the cost measure benchmarks, we believe CMS must take steps to inform physicians about their target spending and patient population throughout the measurement period. **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.** 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. This is especially critical when CMS introduces new cost measures to MIPS as physicians have no reference point for the benchmarks.

CMS should also provide patient attribution information to physicians on a rolling, close to real-time basis during the current measurement year. Because the cost measures utilize new and complex attribution methodologies, 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 current measurement year, we recommend 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 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 to increase awareness of the measures. One effective way to display and disseminate this information to practicing physicians would be through the QPP portal.

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 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. CMS should look to the field-testing reports prepared during the development of new cost measures as a good example of a detailed report including actionable data for physicians.

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 immediately release the 2019 QPP Public Use File (PUF) and 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, alternative payment models (APMs), and MIPS Value Pathways (MVPs).**

Stakeholders remain in the dark about the trends in the 2019 QPP, as CMS has yet to release either a QPP Experience Report Appendix or QPP PUF. To make matters worse, CMS and its contractor, Acumen, LLC, requested comments on the first episode-based measures, which went into effect in 2019, but comments were due prior to release of any resources providing data on how physicians performed on the episode-based cost measures in MIPS. **We urge CMS to immediately release the 2019 PUF with detailed information about how physicians participated in and performed in MIPS in the 2019 performance period.**

Moreover, the AMA has consistently heard that it is challenging for members of the general public to navigate the PUF and even more challenging to draw conclusions at an aggregate level about how specific specialties are being impacted by specific cost measures. When the Value-based Payment Modifier was still in effect, CMS released more detailed specialty-specific performance data. **We urge CMS to provide physician specialty societies with detailed QPP and administrative claims data that builds on the Quality and Resource Use Reports (QRURs) from prior programs**. **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. The AMA has previously made five recommendations to improve the cost measure information provided in the QPP Experience Report and Appendix and is reiterating them again:

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.

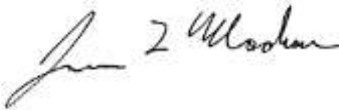
3. We encourage CMS to include information about the administrative claims measures, including all-cause readmission, total per capita cost, and Medicare Spending Per Beneficiary. It would be helpful to see the average score by specialty, geographic location, and practice size.

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.

Thank you for your consideration of our recommendations and comments about the importance of data sharing and transparency in MIPS. If you have any questions, please contact Jennifer Hananoki, Assistant Director, Federal Affairs, at jennifer.hananoki@ama-assn.org or 202-789-7446.

Sincerely,



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