

March 05, 2021

Elizabeth Richter  
Acting 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 Acting Administrator Richter:

The undersigned physician organizations agree with the Centers for Medicare & Medicaid Services' (CMS) aims in the Merit-based Incentive Payment System (MIPS) Value Pathway (MVP) to establish an option that moves the program away from a very individualistic method of reporting to a more holistic, episodic or condition-focused approach with a clear end goal of improving patient outcomes. We greatly appreciate the ongoing dialogue between CMS and our organizations about opportunities to improve patient care through MVPs. CMS should not feel pressured to rush into launching MVP as it is more important to ensure that each MVP is well-designed with agreement from the relevant specialties. Due to the COVID-19 public health emergency, practices have had the option to opt out of MIPS since 2019. We offer the below recommendations to ensure the MVP is successfully implemented and we strongly urge CMS to address these issues in the 2022 Quality Payment Program proposed rule.

#### Reinventing MIPS to Ensure MVPs Fulfill Their Aims

For the MVP to achieve its stated goals of improving outcomes for patients and giving patients information about where to go for high-quality, efficient care, CMS must reinvent its existing approach to performance measurement in MIPS. Our principal recommendation to CMS is that the MVP needs to pivot away from the status quo and siloed categories within MIPS in order to be successful. MVPs should not merely be an extension of the specialty measure sets. Rather than taking a metric perspective, we recommend CMS look at MVPs as a cohesive quality program and implement MVPs that are thoughtfully designed by physician specialty societies to improve patient outcomes, including MVPs that are multi-specialty and sub-specialty focused.

Central to MVP development should be an answer to the question: what is the larger goal that MVP will address? Does the MVP inform patients about high-quality care that is relevant to them, incentivize care coordination, or improve quality of life? Does the MVP address avoidable costs by helping patients prevent costly exacerbations, disease progression, complications, or duplicative services? For example, diabetes prevention should be a high-priority MVP because it would help people avoid costly diabetes care, as well as kidney, ophthalmic, and other sequelae of diabetes.

One significant downside to exclusively relying on existing MIPS measures and improvement activities is a trend toward a one-size-fits-all template for MVPs. There is no one-size-fits-all approach to improving quality, ensuring efficient resource use, and leveraging innovative technology for Medicare patients. While a small number of procedure-focused MVPs may leverage one of the 18 existing episode-based cost measures, MVPs focused on other procedures, conditions, or clinical

priority areas, such as appropriateness of care, will require CMS to work with the specialty societies and other stakeholders to identify, develop, and test new measure concepts.

For example, the current draft Advancing Care for Appropriate Colon Health MVP is not meaningful to gastroenterologists due to CMS's removal of Measure 343: Screening Colonoscopy Adenoma Detection Rate (ADR) as a quality measure from the Quality Payment Program beginning with the 2020 performance year. ADR is the best-established colorectal neoplasia-related quality indicator and research demonstrates that high rates are associated with significant reductions in colorectal cancer risk. An MVP focused on colorectal cancer prevention, without also tracking ADR, does not make clinical sense to gastroenterologists who have adopted this internationally recognized metric for high-quality screening colonoscopy.

#### MVP Design and Prioritization

We understand CMS is concerned about a proliferation of MVPs, and this fear is guiding CMS to limit MVPs to overly broad measure sets that, in some cases, would compare physicians in the same specialty that have differing sub-specialization against one another. We have significant concerns with this approach as it repeats many of the problems with traditional MIPS—notably a lack of clinical relevance to physicians and patients. This approach also fails to account for sub-specialization and varying practice arrangements. For instance, cancer refers to many different diseases so an MVP must account for these considerations to be meaningful to disease site specialists in oncology and patients with specific cancers. This includes not only the quality measures, but also the cost and population health measures. Therefore, ASCO proposed an MVP that is specific to lung cancer; however, CMS has chosen to pursue a generic Advancing Cancer Care MVP instead. We support an approach to MVP development that holds physicians accountable for costs under their control and quality during an episode of care.

Similarly, many of the quality measures included in the draft eye care MVP are not relevant to all ophthalmologists—which consists of eight distinct subspecialties with little overlap—and would not accurately show comparisons among subspecialists. Additionally, the draft MVP is based off one cost measure focused on cataract surgery. Outside of cataract surgeons and comprehensive ophthalmologists, many ophthalmologists, such as retina specialists, do not typically perform cataract surgeries except in rare circumstances and thus would not be eligible for the cataract cost measure.

Alternatively, we strongly urge CMS to work closely with the national medical specialty societies to develop an MVP prioritization framework. We stand ready to identify opportunities to develop an MVP based on valid, reliable MIPS and Qualified Clinical Data Registry (QCDR) measures; inform CMS about specialty societies' initiatives to drive quality improvement that would require new measure concepts, such as prevention of diabetes; and agree on additional high-target areas to reduce avoidable costs and improve quality.

CMS must then begin to explore the results that the proposed components within each category of an MVP could produce, using existing data and benchmarks. This modeling would enable CMS, relevant specialties, and patients to understand how the performance scores and other information such as improvement activities could inform quality improvement and patient choice, and how scoring and representation of the results should be displayed. We recognize specialty organizations could attempt to model some of the information by using the 2018 MIPS public use file. However,

the 2018 file did not include the episode-based cost measures or the revised All-Cause Readmission, Medicare Spending Per Beneficiary, and Total Per Capita Cost measures. The public use file is also scrubbed by CMS prior to publicly posting so CMS is the only group that has access to the necessary data. Therefore, CMS must provide this data to specialties and work with them to reach answers to the following questions:

- Are the measures used within the quality and cost category meaningful to patients and informative to clinicians?
- Is there sufficient variation across those reporting the quality measures to make meaningful comparisons?
- How should the cost data be presented such as identifying outliers rather than the current 10-decile approach?
- What percentage of the specialty currently reports the quality measures and has the cost measure(s) attributed to them?

In future years, CMS should continue to explore what the results of an MVP represents. We anticipate that our understanding of the quality and cost constructs will continue to evolve and the approaches to scoring and displaying the results may vary based on the procedure or clinical condition, size or location of a practice or other variables that are not yet identified.

#### MVP Scoring

We are concerned that few physicians will choose MVPs as the possibility of failure and a potential 9 percent Medicare penalty may be a serious barrier to overcome. Although we welcome and have long sought a requirement for fewer quality measures to be reported, CMS has also been vague on how it plans to operationalize scoring physicians on four quality measures, particularly the methodology and calculations it plans to use and incentivize participation in MVP. CMS should design MVP scoring to address these concerns. This is especially critical in light of the COVID-19 public health emergency, which has disrupted participation in MIPS in 2019, 2020, and 2021. We continue to urge CMS to establish a bonus payment to hold physicians harmless from steep penalties as they transition to MVPs, similar to the gradual implementation of MIPS and given the statute restricts CMS' ability to pilot test MVPs.

To further reduce complexity and allow physicians to better predict how they will perform on MVPs, we recommend that CMS move to multi-category credit. Improvement Activities support quality and cost goals and are inherently captured in the data for those categories; there is no need to separately attest to check a box. Ideally, the entire Improvement Activities category should be automatically satisfied by participation in an MVP, which requires physicians to forego the option of selecting whichever measures they desire in MIPS to focus on an episode of care or clinical priority area.

Moreover, the Promoting Interoperability (PI) category measures are too limiting to benefit MVP participants. Tying check-the-box performance measures to an MVP misses the intent of moving away from the MIPS status quo. Certified EHR Technology (CEHRT) is already widely in use and we expect that EHRs will play a key role in supporting the care coordination necessary for MVP success. Anchoring an MVP to PI requirements may also unintentionally prevent physicians from adopting non-CEHRT like remote patient monitoring or telemedicine tools for fear they will not "count" in PI. Furthermore, engaging patients and interoperability are already critical to value-based care and there are far greater and more meaningful incentives found in recent Information Blocking

regulations. CMS should only require physicians to provide an affirmative attestation that they adopt, implement and use CEHRT to exchange electronic health information to receive full PI credit in an MVP. CMS has recently taken the positive step toward such an approach by allowing eligible clinicians to attest to two measures in the PI program. Finally, we urge CMS to take full advantage of the flexibility to demonstrate use of CEHRT (e.g., straightforward attestation) found in The Health Information Technology for Economic and Clinical Health Act.

#### Voluntary MVPs

The undersigned organizations strongly oppose retiring traditional MIPS and making MVP participation mandatory. MVPs should incentivize participation by reducing the need to report for the sake of reporting in MIPS, allowing physicians to focus their quality improvement efforts in Medicare around a singular clinically relevant episode of care and patient outcome, and implementing simplified scoring policies, including multi-category credit.

Thank you for your attention to these recommendations. We welcome the opportunity to continue working with CMS to identify opportunities to improve quality and efficiencies in the Medicare program via MVPs.

Sincerely,

American Medical Association  
AMDA - The Society for Post-Acute and Long-Term  
American Academy of Allergy, Asthma & Immunology  
American Academy of Dermatology Association  
American Academy of Family Physicians  
American Academy of Hospice and Palliative Medicine  
American Academy of Neurology  
American Academy of Ophthalmology  
American Academy of Otolaryngic Allergy  
American Academy of Otolaryngology- Head and Neck Surgery  
American Academy of Physical Medicine and Rehabilitation  
American Association of Neurological Surgeons  
American Association of Orthopaedic Surgeons  
American College of Allergy, Asthma and Immunology  
American College of Cardiology  
American College of Gastroenterology  
American College of Obstetricians & Gynecologists  
American College of Physicians  
American College of Radiology  
American College of Rheumatology  
American Gastroenterological Association  
American Psychiatric Association  
American Society for Clinical Pathology  
American Society for Gastrointestinal Endoscopy  
American Society of Cataract & Refractive Surgery  
American Society of Plastic Surgery

American Society of Retina Specialists  
American Thoracic Society  
American Urological Association  
Association for Clinical Oncology  
Association of American Medical Colleges  
College of American Pathologists  
Congress of Neurological Surgeons  
Heart Rhythm Society  
Infectious Diseases Society of America  
Medical Group Management Association  
Society for Cardiovascular Angiography and Interventions  
Society for Vascular Surgery  
Society of Hospital Medicine  
Society of Interventional Radiology  
Society of Thoracic Surgeons  
Spine Intervention Society