



January 14, 2021

Seema Verma, MPH  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services

Dear Administrator Verma,

The American College of Physicians (ACP) thanks the Centers for Medicare & Medicaid Services (CMS) for this opportunity to provide written feedback on the ongoing design and future implementation of the MIPS Value Pathway (MVP). The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 163,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

The College is one of a handful of organizations to submit MVP proposals for consideration in 2020. We submitted two, one on preventive care management, and a second on chronic disease management. We have since engaged in two meetings with CMS and have one more scheduled, and have corresponded over multiple emails. While there are still outstanding areas that we hope to find common ground on, outlined in these comments, we look forward to continued, productive conversations and collaboration.

We appreciate CMS' ongoing efforts to incorporate stakeholder input into the design and implementation of MVPs, which we agree is integral to its success. We were pleased to share oral comments at the CMS MVP Town Hall on January 7, 2021, and are pleased to follow up with these written comments, which are organized according to the three topic areas of the Town Hall. To summarize our thoughts, **ACP supports the overarching concept of MVPs. However, based on the information provided at this point, we are not convinced MVPs go far enough to address the underlying issues or distinguish themselves in a meaningful way from traditional MIPS.** To do so, CMS must: 1) truly create more synergy between the performance categories; 2) revamp the Promoting Interoperability Category; and 3) improve cost measurement. Additionally, ACP cannot support the inclusion of any measures that ACP's Performance Measurement Committee (PMC) has [rated](#) as invalid.

If you wish to discuss further, or have any questions, please contact Shari Erickson, Vice President of Governmental Affairs and Medical Practice, at [serickson@acponline.org](mailto:serickson@acponline.org) or 202.261.4551.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Mire", enclosed within an oval shape.

Ryan D. Mire, MD, FACP  
Chair, Medical Practice and Quality Committee  
American College of Physicians

## Subgroup Reporting

Like others expressed during the Town Hall, **ACP strongly opposes making sub-group reporting mandatory.** Doing so would represent a huge increase in reporting burden, particularly for large multispecialty practices. ACP appreciates CMS' desire to dispense performance data and feedback at more targeted levels, but notes that providing data and performance insights at individual clinician or sub-group levels is possible, while scoring and posting for public purposes at the group practice level. As part of ACP's [New Vision](#) for U.S. healthcare, ACP recommends moving toward a limited set of patient-centered, actionable, appropriately attributed, and evidence-based measures for public reporting and payment purposes, while supporting the use of additional clinically meaningful measures for internal quality improvement purposes. This reinforces clinical care teams, which ACP strongly [supports](#).

Regarding scoring, **ACP supports applying the highest of scores reported.** This encourages participation and minimizes errors that could arise during subgroup selection or assignment. There is precedent with facility-based scoring. ACP supports physicians being able to select MVP reporting when submitting MIPS data at the end of a performance period (as opposed to midway through the performance year). This approach provides more time to make the decision and better accounts for NPI/TIN changes during the performance year, which far outweigh any drawbacks. In general, flexibility in reporting is critical to reducing burden while increasing clinical relevance and patient-centeredness.

## MVP Design

**In creating MVPs, ACP greatly appreciates CMS being responsive to past physician frustrations with MIPS. We strongly endorse the concept of MVPs and CMS' goals for them,** including being more patient-centered, using more clinically relevant metrics, streamlining performance categories to reduce burden, and facilitating the transition to Alternative Payment Models (APMs).

**If MVPs are to achieve these laudable goals, ACP strongly believes that MVPs must be a wholesale departure from traditional MIPS. We worry that current designs, as laid out in the [Town Hall Preparation Guide](#), do not go far enough to address some of the underlying issues with MIPS.** ACP appreciates that in the 2021 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) final rule, CMS states that they may revisit the Promoting Interoperability (PI) Category in the future, but for now consider it a "foundational layer" of MVPs. Similarly, the Agency says they are open to more targeted cost metrics in the future, but notes that this would take years to develop. **At this point in time, it is unclear how MVPs would meaningfully differ from specialty measure sets under traditional MIPS.**

**ACP supports the MVP concept and would like it to move forward as soon as possible. However, we believe it is important to get it right.** MVPs represent a critical juncture in the evolution of MIPS and the larger QPP. It offers a unique opportunity to critically evaluate the shortcomings of MIPS and devise meaningful, long-lasting solutions to make the program more effective and workable for years to come. **If CMS is open to more robust reforms in the future, reforms that ACP and a vast majority of stakeholders support, it should make these changes prior to implementing MVPs.** As CMS alludes to in the 2021 PFS/QPP final rule, physicians are weary of the near relentless program and requirements changes. Rather than push forward with an MVP implementation in 2022 that is more different in name than in structure, and delaying larger scale changes to future performance years, CMS should take the time to get it right from the outset, even if that means delaying initial implementation of MVPs.

Among other necessary changes to truly reinvent MVPs, CMS must:

- **Create synergy across the four performance categories. To do so, we must stop thinking of each category as siloed and look for opportunities to leverage existing data to satisfy requirements for multiple categories, when relevant and appropriate.** The College would like to clarify here that we are not asking CMS to lower the rigor of its criteria. We are asking CMS to leverage existing data rather than require physicians to perform an arbitrary second action for the sole purpose of checking a box for data reporting purposes. A simple and prevalent example occurs every time a physician reports quality data via an electronic health record (EHR), thereby sending CMS the quality data it needs while simultaneously demonstrating use of an EHR. This action should qualify for credit towards both the Quality and PI Categories.
- **For the PI Category, ACP supports a menu of attestation-based measures similar to the Improvement Activities category that would more accurately reflect the many innovative ways practices are already leveraging emerging innovative Health Information Technology (IT) to improve patient care.** Importantly, this would allow CMS to streamline PI activities around distinct patient populations, conditions, and medical specialties, which will be critical for future MVP development. It also gives the category the necessary flexibility to evolve capturing new innovative technologies as they emerge and continue driving toward innovation well into the future, which is particularly important for a field as fast-moving and ever-changing as Health IT.
- **For the Cost Category, CMS must lead the charge in developing new metrics that are more actionable and targeted to specific specialties, patient populations, and conditions. We implore CMS to lead the charge in this development rather than relying on individual stakeholders to do so.** ACP understands through its Council of Subspecialty Societies that developing measures is cost prohibitive for a number of medical subspecialties and doing so would likely result in development delays and gaps across smaller medical specialties and subspecialties. The importance of more targeted cost metrics to future, more accurate performance measurement was a common rallying cry at the MVP Town Hall. ACP implores CMS to act on this clear directive by prioritizing CMS development of targeted cost measures, which we realize is a multi-year process. However, this is an instrumental piece to the future success of MVPs and performance measurement in general and the building must start now.

**ACP strongly supports voluntary selection of MVPs.** We do not feel CMS assigning of MVPs is optimal or necessary. As those with the clinical expertise and understanding of their unique patient populations, it is critical that clinicians have the option choose which MVPs are most relevant to their specialty and unique patient populations. Another important advantage to physician selection of MVPs is that it would help to avoid potential downstream complications or delays that could arise from sub-group reporting if CMS prospectively assigns MVPs. In terms of ensuring clinicians choose “appropriate MVPs,” this is just one of the many reasons why robust minimum reliability and case minimums are so important.

**ACP does not support retiring "traditional" MIPS, nor do we think it is necessary.** If the MVP achieves its goals of reducing reporting burden, being more clinically relevant, etc., physicians will want to move to MVPs. That said, under no circumstances should CMS retire traditional MIPS before: 1) a comprehensive menu of MVPs are available to accommodate all specialties, practice sizes, and geographic locations; and 2) only a small minority of clinicians are still in MIPS.

The College appreciates CMS' question about how to encourage participation in MVPs over traditional MIPS reporting. Requiring fewer than six actively reported quality measures would be one simple option to reduce burden and incentivize clinicians to make the switch to MVPs, as would creating more synergy across categories and reducing the overall number of separate reporting requirements. ACP also supports a moderate amount of bonus points to reward early adopters for switching to MVPs in its initial years of implementation. We suggest that CMS make the bonus points available until the point that the vast majority of clinicians have available MVPs to report.

**In the interest of expediently developing MVPs, the College supports initially focusing on developing MVPs around existing specialty measure sets or existing APMs. We also see the value in providing clinicians who participate in these MVPs with a future glide path to APM participation. However, we do not want any sort of formal classification to result in CMS assigning lower priority to MVPs where there is not already an existing specialty measure set or APM, particularly given the shortage of specialty-focused models.** After this initial period, future development of MVPs should make a concerted shift to focus on areas where there are critical gaps, including particular underrepresented patient populations, medical conditions, or specialties. Making more data publicly available, including Medicare claims data, would also help to expedite APM development and participation because practices would be able to perform necessary cost benefit analyses. Also important, stakeholders can leverage this same data to inform development of future APMs, including specialty-focused models.

### **MVP Reporting Requirements and Scoring**

**ACP appreciates CMS being responsive to stakeholder feedback and adjusting their course to include measure selection.** Having measures to choose from does not increase complexity but it does minimize reporting burden and helps ensure metrics are sufficiently clinically relevant for specific patient populations, medical specialties, and conditions.

**ACP also supports requiring fewer measures to be actively reported, which reduces administrative burden on clinicians, one of the College's top advocacy priorities. However, ACP has previously voiced several concerns with administrative claims measures to date that we would expect to be addressed before inclusion in any MVPs,** including a lack of actionability to meaningfully influence patient outcomes, particularly at the individual clinician level.

**While the College appreciates CMS' desire to compare across practices, having a set of mandatory, broad measures across MVPs moves in the opposite direction of enhanced clinically relevant data for patients and physicians and undercuts the intent behind MVPs.** Measures that are clinically relevant to one specialty are likely not relevant or appropriate for another, and that is the point. Measures that compare across specialties and geographic regions are far too general to be actionable on the part of the individual clinician to improve patient outcomes or to provide patients with meaningful information with which to compare and select physicians. It is more useful to focus on measures that offer meaningful, clinically relevant information for comparable specialists, diseases, and patient populations.

**Every measure or activity should be held to transparent, consistent standards for statistical reliability, actionable impact on patient outcomes, and clinical evidence base.** Good performance measurement programs cannot be built on a foundation of weak measures. ACP [believes](#) measurement at the group practice or clinical team level is most appropriate for public reporting and payment purposes, while supporting the use of additional metrics for internal quality improvement efforts. CMS' current average

minimum reliability of 0.4 for episode-based cost measures is insufficient. Increasing case minimums can improve measurement accuracy. While this may result in fewer clinicians being counted, it is preferable to clinicians having their payments adjusted based on measures of questionable reliability and validity.

ACP appreciates CMS' specific question relating to case minimums and category reweighting. The College strongly believes that case minimums are critical to ensuring the measurement accuracy. Under no circumstances should physicians be scored on measures for which they do not meet a sufficient case minimum requirements, even if that leads to reweighting of a particular category. This is precisely why CMS was given the authority to reweight categories in select circumstances in the first place.

**Over the past several years, ACP's Performance Measurement Committee has [reviewed](#) hundreds of MIPS measures based on detailed evaluation criteria and found a good proportion to be invalid as currently designed. ACP cannot support the inclusion of such measures, either in traditional MIPS or new MVPs.** In many cases, ACP provided technical recommendations to improve individual measures and welcomes an opportunity to further discuss with CMS our concerns regarding specific measures.

ACP appreciates that CMS is open to more "specific" and "meaningful" cost measures for a given MVP in the future. As noted earlier, we urge CMS to lead the charge in developing these metrics with all due expediency. We understand that CMS has begun developing episode-based cost metrics. In many cases, the National Quality Forum's Measure Applications Partnership (MAP) clinician workgroup has supported the intent behind the measures, but raised several methodological concerns, rating most as "do not support with potential for mitigation." They have also raised the importance of pairing cost measures to comparable quality measures, which bodes well for the future of MVPs, but will take time. **We urge CMS to work collaboratively with stakeholders and take the proper time to address underlying methodological concerns and get cost measurement right.** Many of the suggested changes apply across multiple cost measures, such as concerns with patient attribution. We commend CMS for participating in these conversations and underscore the importance of leveraging clinician and stakeholder expertise such as the MAP clinician workgroup in measure development to help ensure all performance metrics, particularly cost measures, are clinically relevant and accurate. **We recommend that all MIPS and MVP performance measures receive approval from the MAP prior to CMS approval and implementation,** which additionally supports CMS transparency and accountability.

In the interim, we understand CMS' desire to evaluate clinicians on cost, and we appreciate recent changes to improve the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measures. However, **ACP continues to voice several outstanding concerns with existing cost measures that we believe CMS needs to address prior to MVP implementation.** Specifically, cost measures should only be attributed at the group/practice level or higher, the same costs should never be attributed to multiple clinicians or groups, and all cost measures should risk adjust for social determinants of health and be within a practice's reasonable ability to influence the outcome.

**ACP strongly supports CMS' planned inclusion of QCDR measures within MVPs and was highly encouraged to hear CMS state in the Town Hall that it is open to allowing MVP developers to include QCDR measures that are simultaneously undergoing approval.** ACP agrees with CMS that final inclusion in the MVP would be conditional on each QCDR measure receiving final approval from CMS. ACP believes that this approach is an optimal strategy to expedite development of MVPs while preserving the integrity of individual measure standards. CMS' plan to incorporate some degree of measure selection makes this plan more ideal, since approval of an MVP would not be contingent on a single

measure. ACP greatly appreciates CMS being responsive to stakeholder feedback on this point and requests that the Agency issue relevant guidance, particularly given that in the 2021 PFS/QPP final rule CMS had previously stated that QCDR measures must meet all existing criteria and be fully tested prior to being included in an MVP and that only QCDR measures that were approved in the previous year may be considered for inclusion within a candidate MVP.

In terms of scoring, ACP supports CMS pursuing strategic priorities and welcomes CMS to incorporate these when selecting which measures to include. **However, we strongly caution against CMS formally adding more layers of complexity to MVP scoring with sub-categories or weighting.** Generally, ACP believes points should correspond to their relative weight to the category and overall MIPS composite score, which makes it much easier for clinicians to understand their relative weight than the current maze of separate scoring methodologies and point systems for each performance category.

### **General Feedback about the Town Hall**

ACP greatly appreciates CMS' willingness to engage with stakeholders in pre-rulemaking and incorporate their feedback into the design and implementation of MVPs, which we believe is critical to the future success of MVPs. We thought the Town Hall format was effective, particularly the detailed background information and specific, technical questions that were distributed in advance via the Preparation Guide, which allowed us to provide more meaningful feedback on CMS' specific proposals.

It is ACP's understanding that registration for the event filled quickly. ACP heard from multiple specialty societies that they were not able to be moved from the waiting list prior to the event. While we appreciate there are always logistical and budget constraints to consider, hearing from a diverse range of stakeholder and specialty voices is critically important. In the future, we would urge CMS to find ways to expand the capacity or hold multiple Town Halls to ensure all voices can be represented.

ACP enjoyed the thoughtful discussion related to MVP design and requirements and scoring (Sessions 2 and 3). We believe the discussion could have benefitted from more time.

On net, the College found the Town Hall format, particularly the preparatory information and questions, to be productive and appreciate the opportunity to voice our thoughts through oral and written comment. We look forward to continuing to engage with CMS on the design and development of MVPs.