April 10, 2020

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

Dear Administrator Verma:

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 reduce burden and focus reporting around an episode of care and patient outcomes. The high-level framework outlined by CMS in last year's Quality Payment Program (QPP) rule was an important step in the right direction, but we believe that the MVP pathway needs to be structured appropriately to effectively improve the relevance of MIPS to clinical practice and reduce unnecessary paperwork burdens. **Specifically, we strongly recommend that CMS ensure that MVP participation is voluntary, create a transition period, focus on measures that are meaningful to physicians, promote the use of new and innovative health information technology, dramatically reduce reporting burden by streamlining reporting, and ensure there are appropriate incentives for physicians to report on new measures and as a sub-group.**

Voluntary Participation
We strongly urge CMS to make MVP participation voluntary and to incentivize physicians to opt-in to MVPs. 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.

Transition to MVPs
As CMS took a gradual implementation approach to MIPS in 2017 and 2018, CMS should also view the first two years of each new MVP as a transition period. It will take time to develop, refine, implement and educate physicians about the specific features of an MVP. Physicians may also be concerned that by adopting the new MVP approach, they will be at risk for a negative payment adjustment. **We urge CMS to hold physicians harmless from a penalty for the first two years of participation in a new MVP**. This transition period should be rolling and begin when a new MVP is introduced into the program. Although several specialty societies are submitting an MVP proposal for 2021, most physicians will not have an MVP option in the near term. In addition, a transition period is critical for incentivizing specialists who have been participating at a group level but would move to sub-group participation in an MVP, which is potentially more administratively burdensome than reporting as a group.

CMS should consider the expenses to adopt and administer an MVP for physicians in small practices who have been reporting via claims, as well as physicians in health systems and group practices that have been reporting via the CMS Web Interface. We urge CMS to consider incentives to participating in MVPs, such as aligning scoring of MVPs with MIPS alternative payment models (APMs) and across payment systems similar to the facility-based scoring methodology.

Developing MVPs

We appreciate that CMS is taking a collaborative approach to co-developing MVPs with physician specialty societies. However, physician specialty organizations are operating without key information, such as data about attribution of the new cost and population health measures. **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.** 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.

Stakeholders have received mixed messages about the purpose and prioritization of MVPs – whether to align MIPS categories toward improving a patient outcome or to compare physicians in the same specialty against one another. While CMS has stated it will initially implement MVPs based on existing measures, 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 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.

Another obstacle to developing MVPs is the timeline for implementing a measure into MIPS. Multiple stages in the measure development timeline and CMS' requirements for measure developers to propose a measure for MIPS significantly delay acceptance of a new measure. For example, to propose a measure for the 2020 MIPS program, a measure developer must have submitted their application to CMS by June 1, 2018. We urge CMS to consider changes to the existing timelines for reviewing clinician measures to shorten the review time and better align with Physician Fee Schedule/QPP rulemaking cycle. The Measure Application Partnership (MAP) is set up to align with the Inpatient Prospective Payment System rulemaking cycle. We welcome a conversation with CMS on ways to improve the MAP process, including better ways to enhance engagement and physician specialty involvement and feedback.

In addition, there has been a lack of clarity about how CMS plans to integrate qualified clinical data registries (QCDRs) into MVPs. Overall, we believe that physician specialty-led QCDRs can play an integral role in developing and refining meaningful MVP measures. **Therefore, we strongly encourage you to provide more details in the upcoming QPP proposed rule about how QCDRs and QCDR measures can be included in MVPs.** We recognize the need to propose MVPs through rulemaking and that the QCDR review process happens separate from rulemaking. However, we do not believe this should prohibit QCDRs from proposing new measures as part of MVPs or require QCDRs to go through the formal measure under consideration process. We recommend that if a QCDR plans on proposing a new measure for use within an MVP, then the title and concept would be presented to CMS prior to the proposed rule, but the QCDR steward has the proceeding months to fine tune and work with CMS on the final specifications. If during the development cycle, it is determined the measure is not feasible, the QCDR would have to inform CMS prior to release of the final rule, and CMS could not finalize the MVP for the given program year. We do not envision that a measure concept and title would drastically change between the proposed and final rule and QCDR deeming process.

Population Health Measures

We oppose the use of population health administrative claims-based measures in MVPs. Many of the existing administrative claims measures have not been tested at the physician level, are based on retrospective analysis of claims, and do not provide granular enough information for physicians to make improvements in practice. The measures lead to inaccurate assessments about care and result in confusion due to the inability to accurately assign responsibility of care. The measures also move the program away from incorporating the patient's voice. Physicians treat patients at the individual level, not the population

health level, so measuring them on population health measures often holds them accountable for things outside of their control. **Measures that should be included in MVPs are those that have been developed by physician-led organizations, such as specialty societies, to ensure they are meaningful to a physician's practice and patients and measure things a physician can control.** Therefore, if CMS insists on including population health measures then it must broaden what it considers and how it defines population health measures, as well as allow specialty societies to develop and propose population health measures as part of their MVP proposal.

Streamline Reporting
While the MVP framework bundles measures together in a specific clinical area, we are concerned the framework still requires physicians to report in each performance category and maintains the status quo with Promoting Interoperability (PI) and Improvement Activities (IA) categories. **CMS should eliminate the need for physicians to report in four separate performance categories and revise the PI and IA to eliminate reporting for the sake of reporting.** Rather than a physician having to attest to IAs, the developer of each MVP should note to CMS which IAs clinicians are inherently performing as part of a particular MVP, and corresponding IA credit should be automatic. This is similar to how MIPS alternative payment models (APMs) and recognized patient-centered medical homes are currently scored in the IA performance category.

A physician should also be able to attest that they (or at least 75% of the eligible clinicians in their group) are using certified electronic health records technology (CEHRT) or health IT that interacts with CEHRT, rather than reporting on individual PI measures. Doing so would engage clinicians who are non-patient facing that are currently exempt from the category (e.g., radiologists who use imaging equipment, but not EHRs). For instance, MVPs utilizing electronic clinical quality measures are by definition using CEHRT to collect, report, and submit data based on CMS' Implementation Guides. Relatedly, practices participating in MVPs that utilize a QCDR could receive full credit in PI if they also have a certified EHR to enable e-prescribing and e-prescribe for at least one patient (unless an exception applies). This would incentivize physicians to continue participating in QCDRs while easing the reporting burden associated with PI. It would also reward doctors who seek to utilize emerging health IT for patient care or contribute data for aggregation and quality analysis purposes.

Alternatively, CMS could permit a targeted, focused attestation approach by allowing MVP developers to specify the CEHRT functions that are most relevant to their patients and that episode of care, rather than requiring every MVP to report on every PI measure. Furthermore, PI measures are designed to be "one-size-fits-all" and may detract from the focus of the MVP and inadvertently undermine the outcomes that the MVP is designed to achieve. MVP developers could instead include in their proposal to CMS which CEHRT functionalities the MVP will prioritize to provide value to their patients. Physicians would be required to attest "yes/no" to utilizing those functionalities. For example, a diabetes prevention MVP may want to focus on the use of application programming interfaces, the capture of patient generated health data, and other technologies to engage with patients and monitor blood glucose and/or weight levels. This approach would continue to promote the use of CEHRT while freeing up MVP developers to innovate.

These reduced reporting concepts foster a hybrid approach between MIPS and Advanced APMs and greatly reduce the reporting burden, and better help physicians prepare to participate in APM models. Of note, CMS permits Advanced APMs to use CEHRT in whatever way they choose; physicians preparing to become Advanced APMs should be given the same consideration. They will still need to attest that they are not information blocking to receive MIPS credit and will additionally be subject to ONC's information blocking regulation and HIPAA's patient access requirements.

Thank you for your attention to these recommendations. We welcome the opportunity to work 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 Care Medicine
American Academy of Dermatology Association
American Academy of Neurology
American Academy of Otolaryngic Allergy
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 Emergency Physicians
American College of Obstetricians and Gynecologists
American College of Osteopathic Internists
American College of Physicians
American College of Radiology
American Gastroenterological Association
American Osteopathic Association
American Society for Clinical Pathology
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society of Anesthesiologists
American Society of Nuclear Cardiology
American Urological Association
American Academy of Dermatology Association
American Psychiatric Association
American Society of Retina Specialists
Association for Clinical Oncology
Association of American Medical Colleges
College of American Pathologists
Congress of Neurological Surgeons
Endocrine Society
Heart Rhythm Society
Infectious Diseases Society of America
Medical Group Management Association
Society for Vascular Surgery
Society of Interventional Radiology
Spine Intervention Society