

April 13, 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:

On behalf of the undersigned organizations, thank you for providing much-needed relief for physicians in the Merit-based Incentive Payment System (MIPS) by instating an automatic and flexible Extreme and Uncontrollable Circumstances Hardship Exemption policy for the 2020 MIPS performance year due to the COVID-19 Public Health Emergency (PHE). We write today to urge additional action to provide greater transparency in MIPS. **Specifically, we ask that CMS immediately release the 2018, 2019, and 2020 MIPS cost measures benchmarks and further make cost measure benchmarks and patient attribution information available on a rolling, close to real-time basis during the 2021 performance year and future performance periods thereafter. We also continue to remain concerned with the lack of timeliness on the release and consistency with the quality measure benchmarks.**

We are very concerned that CMS has never published MIPS cost measure benchmarks, despite using these metrics to evaluate physician and group performance in the MIPS Cost Performance Category. Because the benchmarks have not been published, physicians cannot compare their spending to the target in the current performance period or prior periods, nor can they determine whether the benchmarks are fair and valid, accounting for variations in resource use that are within a physician's control. Moreover, physicians cannot identify opportunities to reduce spending or best practices for providing efficient care. We are particularly concerned that the lack of benchmark information may be concealing issues with the cost measures and/or benchmarks, particularly that the measures capture little variation in spending, which when combined with the extremely low case minimums, could penalize physicians for merely one outlier case. The extent to which this limited variation leads one physician or group achieving higher or lower points based on extremely small differences in costs continues to remain unclear. We would also like to understand the impact of the COVID-19 PHE on the cost measures, including the benchmarks, and cannot make this assessment without this vital information.

President Biden has made transparency a cornerstone of his administration. Also, transparency is essential to the validity of MIPS performance evaluations. CMS recognizes this by releasing annual benchmark files for the MIPS quality measures, which display the standard deviation, average, and score ranges for each decile. Without transparency physicians won't be able to begin to evaluate their performance relative to the target. **We urge CMS to immediately release similarly detailed information for the 2018, 2019, and 2020 MIPS cost measures.**

CMS should publish the latest benchmarking information in the cost measure specifications. We also urge CMS to add a section to each of the specifications to clearly identify the areas of overuse or excessive spending, as well as the opportunities (missed or realized) for cost savings, that contributed to variation among physicians in the costs incurred in each episode measure.

While we understand the cost measure benchmarks are based on performance year Medicare claims data and thus are not published in advance of the performance period, 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 in order to increase awareness of the measures. One effective way to display and disseminate this information to practicing physicians would be through the Quality Payment Program portal.

Finally, we call attention to our ongoing, related concern about the lack of timeliness of release of the quality measure benchmarks. For quality measures, CMS typically releases multiple benchmarks for a performance period. For example, in the 2021 MIPS performance year, CMS released the first file of benchmarks on December 31, 2020 and a second file on March 18, 2021. Since CMS releases updated benchmarks with significant changes to individual measure in the middle of the performance period, physicians and group practices may need to readjust or revise their reporting strategy well after the start of the performance period. This inconsistency leads to confusion and inability to focus on improvement. **CMS should release the quality measure benchmarks at least 30 days prior to the start of the performance period and hold harmless physicians by moving to pay-for-reporting when significant updates to benchmarks are made during the performance period.**

Thank you for your consideration of our request and recommendations.

Sincerely,

American Medical Association
AMDA -- The Society for Post-Acute and Long-Term
American Academy of Allergy, Asthma & Immunology

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American Academy of Dermatology Association
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American Academy of Hospice and Palliative Medicine
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American Academy of Ophthalmology
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