January 24, 2025

The Honorable Jeff Wu
Acting Administrator
Center for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: **2026 Proposed Candidate MVPs and Existing MVP Maintenance Feedback Period**

Dear Acting Administrator Wu,

On behalf of the undersigned organizations, we are writing to recommend vital improvements to the existing and candidate Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs). We collectively developed a robust alternative MVP framework focused on grouping MVP measures for chronic health conditions, episodes of care, and major procedures within the broad specialty MVPs that the Centers for Medicare & Medicaid Services (CMS) believes are necessary. Our recommendations would also create better alignment between the hospital Value Based Purchasing programs and MIPS and provide more meaningful quality and cost comparison information for patients. Unfortunately, the previous administration implemented MVPs that do not meet their potential to improve value for Medicare patients. **We strongly urge CMS to take a fresh look at our alternative MVP framework and adopt our recommendations outlined below in the 2026 Medicare Physician Fee Schedule proposed rule.**

On December 11, 2024, CMS released the 2026 Candidate MVPs as well as opened solicitation for feedback on the existing MVPs in the Quality Payment Program (QPP) with comments closing on January 24, 2025. Physicians initially supported the MVP concept for its promise to create more alignment of quality and cost measures and reduce burden in MIPS, but the reality has fallen short. Since the inception of the MVP concept, the AMA and the national medical specialty societies have frequently and actively tried to engage with CMS to provide constructive feedback on how to improve MVPs. These improvements could meet a crucial need to make the QPP more meaningful for patient care and physician participation less burdensome and costly. However, we are once again disappointed with the lack of transparency in developing the candidate MVPs, limited timeline to respond, and absence of much needed changes to MVPs. The lack of responsiveness is further concerning given that CMS continues to signal that it plans to sunset traditional MIPS starting with the 2029 performance year/2031MIPS payment year and make MVPs mandatory. **MVPs must remain optional, and subgroup reporting must be optional even for MVP participants.** CMS should not further burden practices with a regulatory requirement outside the bounds of the statute that requires them to participate in a certain way or report on a program structure that does not make clinical sense.

We reiterate that for MVPs to achieve their core goals, they must:

- Focus on measures that are clinically meaningful to both patients and physicians;
- Align quality and cost measures to assess the value of physician care;
- Ensure a viable path forward for specialty-led Qualified Clinical Data Registry (QCDR) measures; Improve the underlying scoring and benchmark methodology to incentivize reporting on new quality measures and long-standing existing quality measures that have no benchmarks;
- Provide a transition path from the MIPS to Alternative Payment Models; and
- Allow for optional MVP participation and subgroup reporting, including allowing for facility-based reporting within subgroup reporting to better achieve alignment between the hospital quality programs and MIPS, which will also reduce administrative burden.

Unfortunately, to date, there are too few relevant MVP quality measures for many acute and chronic conditions, including chronic obstructive pulmonary disease and inflammatory bowel disease, due to the numerous obstacles CMS continues to place on specialty society-led QCDRs and the measure development process. The lack of a viable QCDR option is unfortunate because capturing data through a registry allows for its collection and tracking across various settings and disease states including inpatient versus outpatient settings, acute episodes versus chronic disease, surgical versus nonsurgical interventions, and resource-intensive versus relatively inexpensive therapies. As a result, physicians are forced to use less clinically meaningful measures, reducing the opportunity for quality improvement. Currently, MVPs include mismatches between cost, quality and population health measures that fail to assess the value of care. Finally, many MVPs rely on the flawed Total Per Capita Cost (TPCC) cost measure, which does not assess the costs related to the care provided directly by the physician and penalizes physicians for spending outside their control.

Therefore, **we urge CMS to make the following crucial changes to its MVP approach:**

- Stratify MVPs by health condition or subspecialty, as well as align the quality and cost measures to ensure that quality of care is maintained or improved as costs are maintained or reduced, to assess the value of patient care and to make meaningful comparison information available to patients.
- In coordination with specialty societies, ensure there are quality measures for each subspecialty and for each major type of disease or condition for which beneficiaries receive care and outline a plan for filling the gaps.
- Review appropriateness of health equity measures and inclusion within every MVP.
- Remove current scoring caps on maximum points for ALL topped-out measures and measures without a benchmark for scoring. Topped-out measures can be essential when the goal is cost reduction/control, because they ensure savings are not achieved by reducing quality. New measures are needed to fill gaps, but it will take time to develop them and create benchmarks. There also must be incentives to offset the investment and risk for reporting new measures.
- Better incorporate the use of private sector funded QCDRs and physician specialty society expertise. Utilizing specialty-led QCDRs provides an opportunity to evaluate care

across an entire specialty, as well as at the individual physician level. QCDRS offer continuous feedback to physicians and practices; advance quality measurement towards digital sources; and move beyond snapshots of care, which focus on random individual measures, to a learning system with a broad focus that can readily adapt and grow over time.

- Remove TPCC from MVPs or, at a minimum, substantially revise this problematic measure. Physicians cannot control costs unrelated to the conditions they treat, yet TPCC holds them accountable for all Medicare inpatient and outpatient spending. If any episode-based cost measures are included in an MVP, then TPCC should not be used. If CMS insists on retaining TPCC, it should be revised to separate costs related to each disease or condition, so it is clear which costs are related to a physician's services and therefore within their control.
- Remove the foundational Population Health Category and associated measures requirement. While measuring improvement in population health is important, introducing additional, one-size-fits-all requirements rather than tailoring the selection of measures as appropriate into each MVP is ineffective at improving patient outcomes. It adds an additional layer of complexity with its own burdensome and uneven scoring rules that was never intended by Congress in the MACRA statute. To date, population health measures are also solely administrative claims measures, replicating the same flaws we have repeatedly highlighted with the one-size-fits-all global cost measures like TPCC. For example, the hospital care-focused population health measures are not clinically relevant to many physician specialties.
- While we support a subgroup reporting option to allow specialists in a multi-specialty group to report and be evaluated on relevant measures, we strongly believe this participation method should remain voluntary. Practices should have the option to determine which MVP or MIPS measures are most relevant to the physicians in the practice.

The undersigned organizations have been committed to improving patient care, reducing unnecessary costs, and the successful implementation of MACRA. To our dismay, it has often been a one-sided partnership working with CMS. To better ensure that physicians can find quality measures that are clinically relevant and meaningful for their patients and settings of care, as well as administratively actionable and that ultimately drive better care and value for patients, the agency must move to a more collaborative MVP and measure consideration process with physicians who are the ones delivering the care and reporting these measures. **The undersigned organizations urge CMS to closely evaluate its development process and overall MVP design to ensure there is a sufficient suite of MVPs by condition and sub-specialty**. Thank you for considering our recommendations to improve the design of MVPs and the overall QPP, which is our shared goal.

For a specific breakdown and examples outlining the flaws with the existing MVPs and our recommended alternative approach, please see attachment.

Sincerely,

American Medical Association
Academy of Otolaryngology – Head and Neck Surgery
American Academy of Dermatology Association
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Physical Medicine & Rehabilitation
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Allergy, Asthma & Immunology
American College of Cardiology
American College of Emergency Physicians
American College of Physicians
American College of Radiology
American Gastroenterological Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Gastrointestinal Endoscopy
American Society of Nephrology
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Association for Clinical Oncology
College of American Pathologists
Congress of Neurological Surgeons
Medical Group Management Association
Post-Acute and Long-Term Care Medical Association
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society of Hospital Medicine
Society of Interventional Radiology
Society of Nuclear Medicine and Molecular Imaging
Society of Thoracic Surgeons

# Example: Advancing Care for Heart Disease MVP

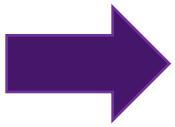
## Has Many Quality & Cost Measures:

- **19 quality measures**
- **5 cost measures**

| ADVANCING CARE FOR HEART DISEASE MVP | |
|---|---|
| **QUALITY** | **COST** |
| Q005: HF: ACE or ARB or ARNI Therapy for LVSD | Heart Failure |
| Q006: CAD: Antiplatelet Therapy | Elective PCI |
| Q007: CAD: Beta Blocker Therapy for Prior MI or LVSD | STEMI with PCI |
| Q008: HF: Beta-Blocker for LVSD | Total Per Capita Cost |
| Q047: Advance Care Plan | Medicare Spending Per Beneficiary |
| Q118: CAD: ACE or ARB Therapy | |
| Q128: BMI Screening and Follow-Up | |
| Q134: Depression Screening and Follow-Up | |
| Q238: Use of High-Risk Medications in Older Adults | |
| Q243: Cardiac Rehabilitation Referral from Outpatient Setting | |
| Q326: A-Fib: Chronic Anticoagulation Therapy | |
| Q377: Functional Status Assessment for Heart Failure | |
| Q392: Cardiac Tamponade/Pericardiocentesis Following Ablation | |
| Q393: Infection After Cardiac Implantable Device | |
| Q441: Ischemic Vascular Disease Optimal Control | |
| Q487: Screening for Social Drivers of Health | |
| Q492: CV-Related Admission Rates for Heart Failure Patients | |
| Q495: Palliative Care Patients Feeling Heard and Understood | |
| Q503: Gains in Patient Activation Measure Scores | |

## Reorganizing by Condition & Service Type Shows Which Measures Apply to Different Subspecialists

| ADVANCING CARE FOR HEART DISEASE MVP | |
|---|---|
| **QUALITY** | **COST** |
| Q005: HF: ACE or ARB or ARNI Therapy for LVSD | Heart Failure |
| Q006: CAD: Antiplatelet Therapy | Elective PCI |
| Q007: CAD: Beta Blocker Therapy for Prior MI or LVSD | STEMI with PCI |
| Q008: HF: Beta-Blocker for LVSD | Total Per Capita Cost |
| Q047: Advance Care Plan | Medicare Spending Per Beneficiary |
| Q118: CAD: ACE or ARB Therapy | |
| Q128: BMI Screening and Follow-Up | |
| Q134: Depression Screening and Follow-Up | |
| Q238: Use of High-Risk Medications in Older Adults | |
| Q243: Cardiac Rehabilitation Referral from Outpatient Setting | |
| Q326: A-Fib: Chronic Anticoagulation Therapy | |
| Q377: Functional Status Assessment for Heart Failure | |
| Q392: Cardiac Tamponade/Pericardiocentesis Following Ablation | |
| Q393: Infection After Cardiac Implantable Device | |
| Q441: Ischemic Vascular Disease Optimal Control | |
| Q487: Screening for Social Drivers of Health | |
| Q492: CV-Related Admission Rates for Heart Failure Patients | |
| Q495: Palliative Care Patients Feeling Heard and Understood | |
| Q503: Gains in Patient Activation Measure Scores | |



| ADVANCING CARE FOR HEART DISEASE MVP | | | |
|---|---|---|---|
| **CONDITION** | **SERVICE** | **QUALITY MEASURES** | **COST MEASURES** |
| Heart Failure | Medical Management | Q005: HF: ACE or ARB or ARNI Therapy for LVSD<br>Q008: HF: Beta-Blocker for LVSD<br>Q377: Functional Status Assessment for Heart Failure<br>Q492: CV-Related Admission Rates for Heart Failure Patients | Heart Failure |
| Coronary Artery Disease | Medical Management | Q006: CAD: Antiplatelet Therapy<br>Q007: CAD: Beta Blocker Therapy for Prior MI or LVSD<br>Q118: CAD: ACE or ARB Therapy<br>Q243: Cardiac Rehabilitation Referral from Outpatient Setting<br>Q441: Ischemic Vascular Disease Optimal Control | |
| | Intervention | Q243: Cardiac Rehabilitation Referral from Outpatient Setting<br>Q441: Ischemic Vascular Disease Optimal Control | Elective PCI<br>STEMI with PCI |
| Atrial Fibrillation | Med. Mgt | Q326: A-Fib: Chronic Anticoagulation Therapy | |
| | Intervention | Q392: Cardiac Tamponade/Pericardiocentesis Following Ablation | |
| Other Rhythm Disorders | Treatment | Q393: Infection After Cardiac Implantable Device | |
| Structural Heart Conditions | Treatment | | |
| Screening and Followup | | Q128: BMI Screening and Follow-Up<br>Q134: Depression Screening and Follow-Up<br>Q487: Screening for Social Drivers of Health | Total Per Capita Cost |
| Other | | Q047: Advance Care Plan<br>Q238: Use of High-Risk Medications in Older Adults<br>Q495: Palliative Care Patients Feeling Heard and Understood<br>Q503: Gains in Patient Activation Measure Scores | Medicare Spending Per Beneficiary |

## Few Quality Measures for Some Conditions & Mismatches Between Quality & Cost Measures

For cardiologists treating **heart failure**:

- 4 quality measures for heart failure
- 1 condition-specific cost measure

For cardiologists *medically managing* **coronary artery disease (CAD):**

- 5 quality measures for CAD
- 0 condition-specific cost measures

For **interventional** cardiologists performing procedures (angiograms and angioplasties) on patients with CAD or AMI:

- 0 measures of the quality of the procedure
- 2 episode cost measures

For cardiologists treating **atrial fibrillation**:

- 1 quality measure for medical management
- 1 quality measure for intervention
- 0 condition-specific cost measures

For **electrophysiologists & other subspecialties**:

- 2 or fewer quality measures
- 0 condition-specific cost measures

**ADVANCING CARE FOR HEART DISEASE MVP**

| CONDITION | SERVICE | QUALITY MEASURES | COST MEASURES |
|---|---|---|---|
| Heart Failure | Medical Management | Q005: HF: ACE or ARB or ARNI Therapy for LVSD<br>Q008: HF: Beta-Blocker for LVSD<br>Q377: Functional Status Assessment for Heart Failure<br>Q492: CV-Related Admission Rates for Heart Failure Patients | Heart Failure |
| Coronary Artery Disease | Medical Management | Q006: CAD: Antiplatelet Therapy<br>Q007: CAD: Beta Blocker Therapy for Prior MI or LVSD<br>Q118: CAD: ACE or ARB Therapy<br>Q243: Cardiac Rehabilitation Referral from Outpatient Setting<br>Q441: Ischemic Vascular Disease Optimal Control | *No Condition-Specific Cost Measure, Only TPCC* |
| | Intervention | *No Current MIPS Measure for Quality of PCI*<br>Q243: Cardiac Rehabilitation Referral from Outpatient Setting<br>Q441: Ischemic Vascular Disease Optimal Control | Elective PCI<br>STEMI with PCI |
| Atrial Fibrillation | Med. Mgt | Q326: A-Fib: Chronic Anticoagulation Therapy | *Only TPCC* |
| | Intervention | Q392: Cardiac Tamponade/Pericardiocentesis Following Ablation | *Only TPCC* |
| Other Rhythm Disorders | Treatment | Q393: Infection After Cardiac Implantable Device<br>Q392: Cardiac Tamponade/Pericardiocentesis Following Ablation | *Only TPCC* |
| Structural Heart Conditions | Treatment | *No Current MIPS Quality Measure* | *Only TPCC* |
| Screening and Followup | | Q128: BMI Screening and Follow-Up<br>Q134: Depression Screening and Follow-Up<br>Q487: Screening for Social Drivers of Health | Total Per Capita Cost |
| Other | | Q047: Advance Care Plan<br>Q238: Use of High-Risk Medications in Older Adults<br>Q495: Palliative Care Patients Feeling Heard and Understood<br>Q503: Gains in Patient Activation Measure Scores | Medicare Spending Per Beneficiary |

# MIPS Scoring Rules Discourage Using Condition-Specific Quality Measures

| ADVANCING CARE FOR HEART DISEASE MVP | | | | | |
|---|---|---|---|---|---|
| | QUALITY MEASURES | | | | |
| CONDITION OR DISORDER | Measures | Outcome | Priority | Bench-mark | Topped Out or 7-Point Cap |
| Heart Failure | Q005: HF: ACE or ARB or ARNI Therapy for LVSD | | | | Capped |
| | Q008: HF: Beta-Blocker for LVSD | | | | Capped |
| | Q377: Functional Status Assessment for Heart Failure | | Y | No | |
| | Q492: CV-Related Admission Rates for Heart Failure Patients | Y | | ? | |
| | | | | | |
| Screening and Followup | Q128: BMI Screening and Follow-Up | | | | Capped |
| | Q134: Depression Screening and Follow-Up | | | | Capped |
| | Q487: Screening for Social Drivers of Health | | Y | | |
| Overall Care | Q047: Advance Care Plan | | Y | | Topped |
| | Q238: Use of High-Risk Medications in Older Adults | | Y | No | |
| | Q495: Palliative Care Patients Feeling Heard and Understood | | Y | No | |
| | Q503: Gains in Patient Activation Measure Scores | Y | | | |

There are 4 quality measures specifically related to **heart failure**, but:

- 2 are capped → max 7 points
- 1 has no benchmark → max 10 points

This encourages/forces cardiologists who treat heart failure patients to use *general* quality measures that have the potential to receive maximum points in MIPS rather than measures specifically related to the *cardiac care* they deliver.

## How To Improve MVP Example: Gastroenterology Care MVP Stratified by Condition/ Subspecialty Showing Gaps & Mismatches

| GASTROENTEROLOGY CARE MVP | | | |
|---|---|---|---|
| **CONDITION** | **SERVICE** | **QUALITY MEASURES** | **COST MEASURES** |
| Colorectal Cancer Screening/ Surveillance | Intervention | Q113: Colorectal Cancer Screening<br>Q185: Colonoscopy Interval w/ History of Adenomatous Polyps<br>Q320: Appropriate Follow-Up Interval in Average Risk Patients<br>GIQIC23: Appropriate Follow-up Colonoscopy Based on Pathology<br>GIQIC26: Screening Colonoscopy Adenoma Detection Rate<br>NHCR4: Repeat Screening Following Poor Bowel Preparation | Screening/Surveillance Colonoscopy<br>+<br>TPCC |
| | | | |
| Inflammatory Bowel Disease | Medical Management | Q275: Assessment of HBV Status Before Anti-TNF Therapy | *No Condition-Specific Measure, Just TPCC* |
| | | | |
| Liver Disease | Medical Management | Q400: Screening for Hepatitis C and Treatment Initiation<br>Q401: Screening for Hepatocellular Carcinoma in Cirrhosis Patients | *No Condition-Specific Measure, Just TPCC* |
| | | | |
| Motility & Functional GI Disease | Medical Management | *No Condition-Specific Quality Measures* | *No Condition-Specific Measure, Just TPCC* |
| | | | |
| Interventional/ Advanced Endoscopy | Intervention | *No Procedure-Specific Quality Measures* | *No Condition-Specific Measure, Just TPCC* |
| | | | |
| Nutrition/ Obesity | Medical Management | *No Condition-Specific Quality Measures* | *No Condition-Specific Measure, Just TPCC* |
| | | | |
| Hepatology/ Transplant Hepatology | Treatment | *No Condition/Procedure Specific Quality Measures* | *No Condition-Specific Measure, Just TPCC* |