September 6, 2016

Andrew Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, DC 20201  
Submitted via www.regulations.gov

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Proposed Rules (Federal Register Vol. 81, No. 136, July 15, 2016)

Dear Acting Administrator Slavitt:

The Medical Group Management Association (MGMA) appreciates the opportunity to submit comments on the rule, “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Proposed Rules” released on July 15, 2016 with file code CMS-1654-P. We look forward to continuing to work with the Centers for Medicare & Medicaid Services (CMS) on the issues in this proposed rule.

MGMA and its 50 state affiliates comprise more than 33,000 administrators and executives in 18,000 healthcare organizations in which 385,000 physicians practice. MGMA represents physician groups of all sizes, types, structures and specialties, and has members in every major healthcare system in the nation. As the leading association for practice administrators and executives for nearly 90 years, MGMA produces the most credible medical practice economic data in the industry and provides the education, advocacy, data and resources that healthcare organizations need to deliver the highest-quality patient care.

In summary, we urge CMS to:

- **Withdraw its administratively onerous global surgical codes data collection proposal** and work with the appropriate medical specialty societies to survey a representative sample of physicians regarding pre- and post-operative visits performed during the global surgical period.
• **Finalize the revised scope of service elements for chronic care management (CCM)** to reduce administrative burdens in furnishing these services and improve payment accuracy for high-severity CCM services.

• **Delay implementation of appropriate use criteria** to ensure alignment with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and readiness of providers and vendors.

• **Clarify eligibility requirements for furnishing care under the expanded Diabetes Prevention Program** and align this model with existing Medicare diabetes education and training services.

• **Allow practices the opportunity to resubmit Value-Based Payment Modifier data** or have composite scores recalculated to reflect all available data upon request.

### Misvalued codes

**Potentially misvalued zero-day global surgical services**

**CMS proposal:** CMS proposes to classify 83 zero-day global surgical codes, listed in Table 7, as potentially misvalued based on the fact that they are billed with an evaluation and management (E/M) service using Modifier 25 at least 50% of the time. These codes have not been reviewed in the last five years and have greater than 20,000 allowed services.

**MGMA comment:** MGMA urges CMS to clarify its valuation concerns regarding separate billing of an E/M service using Modifier 25 during the same visit as a zero-day global surgical code. The use of Modifier 25 indicates the E/M service is medically significant and separate from the global surgical service, rather than inherent in the pre- or post-operative care related to the surgery. For instance, a dermatologist may see a patient suffering from rosacea or psoriasis and, while reviewing their condition and renewing their prescription, notice a suspicious lesion on another body part. The physician may decide to perform a biopsy to diagnose the cause and determine the best course of treatment. In this example, it is not only convenient for the patient but also potentially lifesaving to perform a zero-day global surgical biopsy during the patient’s office visit for a separate diagnosis. MGMA members have provided similar examples, raising doubt about whether CMS has truly identified a valuation issue. Before moving forward with its proposal to consider this code set misvalued, CMS should elaborate on its concern about the use of Modifier 25 to bill a medically significant and separate service provided at the same time as a zero-day global surgical code and enable stakeholders to provide feedback about the level and number of services furnished during these global periods.

**Target for relative value unit (RVU) adjustments to misvalued services**

**CMS proposal:** Due to laws passed in recent years, CMS must meet annual targets for reductions in PFS expenditures by adjusting the RVUs of codes identified as misvalued. For 2017, the annual target is 0.5%. CMS estimates the net readjustment to misvalued codes in 2017...
would be 0.51%, exceeding the 2017 annual target. Because CMS would exceed the target, the reduced expenditure of 0.01% would be redistributed in the PFS in a budget neutral manner. If the misvalued code adjustments fall below the 0.5% target in the final rule, the difference between the net adjustment and the target would be removed from the overall PFS pool and all payments would be reduced through a lower conversion factor.

**MGMA comment**: We recognize the challenge of meeting the 0.5% misvalued code threshold established by Congress and were disappointed the agency missed the target in 2016 due to its narrow approach, thus decreasing overall Medicare physician payments. MGMA continues to suggest a broad approach that fully and accurately accounts for payment changes due to misvalued codes under the PFS and allows the agency to more easily meet the target. In its regulatory impact analysis, CMS estimates that the net reduction of 2017 PFS expenditures in the proposed rule is approximately 0.51%, meaning the agency would meet the target by a mere 0.01%. We once again strongly urge CMS to broaden its approach to counting misvalued code payment adjustments in the final rule. It would be unfortunate if CMS essentially nullified the 0.5% update under MACRA for the second year in a row by taking a narrow approach to the misvalued code target.

**Data collection for global surgical codes**

**CMS proposal**: MACRA requires the agency to “develop and implement a process to gather, from a representative sample of physicians, beginning not later than January 1, 2017, information needed to value surgical services.” This information must include the number and level of visits furnished during 10- and 90-day global surgical periods, and CMS is instructed to use this data to improve payment accuracy of these services by 2019. The agency proposes a three-pronged data collection approach to implement this provision of MACRA. First, CMS would require physicians to report a G-code indicating each 10-minute increment dedicated to a patient before and after a procedure. CMS would establish multiple G-codes to distinguish between the setting of care and whether the services are furnished by a physician or clinical staff. Second, CMS proposes to survey 5,000 physicians about the activities and resources involved in providing pre- and post-operative visits. Third, CMS would conduct an in-depth study, including direct observation of pre- and post-operative care delivered at a number of sites. CMS states it is not proposing to withhold payment for non-compliance at this time, but may do so in the future.

**MGMA comment**: MGMA believes CMS’ data collection proposal would be inconsistent with congressional intent, administratively onerous and unproven to achieve the agency’s goals. In MACRA, Congress prohibited CMS from moving forward with its previously finalized plan to unbundle 10- and 90-day global surgical codes. Rather, MACRA instructs the agency to review and potentially improve its valuation of these services by collecting pre- and post-operative information from a representative sample of physicians. CMS’ proposal would veer significantly from the statute by requiring all physicians to report new, zero-value G-codes for every 10 minutes spent with a patient before and after a procedure beginning Jan. 1, 2017.

Additionally, MGMA is concerned the proposed reporting requirements would impose undue administrative burden on physician practices at a time when they are simultaneously expected to
transition to the new Merit-Based Incentive Payment System (MIPS) or participate in an alternative payment model (APM). For instance, physician practices would need to undergo extensive education and training to ensure accurate reporting of these new codes. If a physician sees a patient for four post-operative visits, each lasting longer than 20 minutes, the practice would bill eight new codes in addition to the global surgical package. By requiring reporting in 10-minute intervals, this proposal would also interrupt clinical work flows by conscripting physicians into setting a stopwatch to determine how many minutes they spend caring for a patient before and after a procedure. Moreover, physician practices would need to update their practice management and electronic health record (EHR) systems to permit reporting of non-billable G-codes. MGMA is also concerned that many clearinghouses and claims processing systems will strip zero-value codes from claims, which may require practices to bill with a $0.01 charge and reconcile the discrepancy in their accounting, leading to even more administrative inefficiencies.

Not only is this proposal inconsistent with MACRA and overly burdensome, but it could generate potentially inaccurate results. Because of the extensive infrastructure updates necessary to begin reporting these proposed G codes, few physicians would be able to comply with the reporting mandate by Jan. 1. This could result in underreporting of relevant services and thus skew the data. More alarmingly, CMS has not pilot-tested the proposed G codes to ensure their accuracy and reliability in measuring the level of service provided during a pre- or post-operative visit. We have concerns that the G-codes do not properly reflect the complexity and medical decision-making inherent to providing these services. Further, many of the codes are not aligned with the E/M services inherent in the global surgical codes. Therefore, these G-codes would likely need to be cross-walked to their corresponding E/M service to meaningfully determine whether the global surgical packages accurately account for the physician work and resources involved in providing these services. In addition, the global surgical packages include many non-patient-facing consultations, such as discussions with radiologists and pathologists, which would not be recognized under this methodology.

MGMA strongly urges CMS not to move forward with the proposed data collection approach. Instead, the agency should proceed slowly by first developing and pilot-testing a sound survey methodology to comply with congressional intent and collect data from a representative sample of physicians. MGMA believes MACRA does not require data collection to begin on Jan. 1, 2017. Rather, the statute requires CMS establish a process to gather information from a representative sample of physicians by Jan. 1. MGMA recommends CMS work closely with the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) and the physician community to determine the most comprehensive and least burdensome manner to conduct a representative sample. At a minimum, the agency should account for different practice types and sizes, as well as specialty mix and location, to mitigate variability in the level and number of services furnished during 10- and 90-day global surgical periods.

**New payments for primary care and care management services**

**CMS proposal:** CMS proposes a number of payment changes designed to increase coverage for primary care, care management and other cognitive services. The agency proposes to adopt CPT
codes 99358 and 99359 to pay separately for non-face-to-face prolonged E/M services before or after direct patient care, which are currently considered to be bundled under the PFS. CMS proposes to create code GPPP6 for separate payment for assessing and creating a care plan for beneficiaries with a cognitive impairment (e.g., dementia).

Additionally, CMS proposes to establish three new G-codes (GPPP1, GPPP2, GPPP3) to separately pay for behavioral health integration services included in the Psychiatric Collaborative Care Model (CoCM). In CoCM, care is provided by a primary care team, which consists of a primary care provider and care manager who work in collaboration with a psychiatric consultant, and includes structured care management with regular assessments of clinical status using validated tools and modifications of treatment. Patients are treated for an episode of care, beginning when the behavioral health care manager engages in care of the patient under appropriate supervision of the treating physician and ending with attainment or failure to attain treatment goals or lack of engagement over a consecutive six-month period. CMS also proposes to create a new G-code (i.e., GPPPX) to pay for behavioral health integration services furnished outside the CoCM.

**MGMA comment:** MGMA continues to support CMS’ efforts to support delivery reforms requiring centralized management of patient needs and extensive care coordination among providers, often on a non-face-to-face basis across an extended period of time. We urge the agency to finalize coverage of these services, as we believe these payments are particularly vital in the context of the forthcoming transition to the MIPS and APMs, as both programs rely on PFS payment as their foundation.

While we understand that the agency believes many of these services lack a corresponding CPT code, we urge CMS to work with the CPT Editorial Panel to develop appropriate codes and adopt such codes when available. Use of CPT codes creates consistency across the industry and reduces inadvertent billing inaccuracies. MGMA also urges CMS to mitigate any unnecessary administrative burdens in billing these new codes, particularly for the non-face-to-face services.

**Add-on payment for patients with mobility-related disabilities**

**CMS proposal:** To improve access and quality of care for patients with mobility-related disabilities, CMS proposes a new add-on G-code (i.e., GDDD1) to pay practitioners for the additional resources involved in providing appropriate care during E/M visits for these patients. For example, these visits can require more physician and clinical staff time to assist the patient in carefully moving and may involve specialized equipment, including wheelchair accessible scales and movable exam tables. CMS estimates the average national payment amount for this new add-on code would be approximately $43.00, including a 20% beneficiary coinsurance amount of about $8.00.

**MGMA comment:** While MGMA supports additional reimbursement for the intensive resources used in furnishing E/M services to patients with mobility issues, we believe the proposal to bill these patients a coinsurance for this add-on code is fraught with unintended consequences, including a potential appearance of discrimination on the basis of disability. In discussions with
MGMA members, we heard that practices would be unlikely to implement this code as proposed because the patient cost-sharing obligation would essentially create a separate class of patients based on disability. These patients represent a vulnerable segment of the population and any additional out-of-pocket cost may exacerbate the access issues they currently experience. We urge CMS to explore alternative approaches to accurately pay for the additional time and specialized equipment used in providing office visits to these patients without increasing the patient’s coinsurance responsibility. CMS should use its demonstration authority to test a similar payment without the cost-sharing element, evaluate patient satisfaction and access, and, if successful, bring the data to Congress for a legislative remedy to allow for expansion of the model that removes any patient cost-sharing element.

MGMA also urges the agency to issue clear and comprehensive guidance on the medical necessity of these codes and their documentation requirements. These requirements must not create an unnecessary administrative burden on physician practices and should mitigate any financial barriers to access for mobility-impaired patients.

**Improvements to chronic care management (CCM) payment and billing requirements**

**CMS proposal:** CMS proposes to mitigate the extensive and onerous requirements to bill CCM services. Specifically, CMS would make the following improvements:

- Limit the face-to-face initiating visit requirement to CCM patients who are new or who have not been seen within the past year, rather than all beneficiaries receiving CCM services. Additionally, CMS proposes to create an add-on payment for initiating visits that involve care planning beyond the scope of the initiating visit.
- Remove the requirement that practitioners furnishing CCM after hours must have access to the electronic care plan.
- Permit billing practitioners to share electronic care plan information with practitioners furnishing after-hours urgent care on a timely basis rather than mandating 24/7 access to the electronic care plan. CMS would also allow transmission of the care plan by fax.
- Modify the requirement to share clinical summaries during transitions of care to require the billing practitioner share “continuity of care” documents.
- Provide more flexibility to practices to determine the best format for sharing a care plan with a patient or a patient’s caregiver.
- Allow documentation of the beneficiary’s consent in the medical record, rather than requiring a written agreement.
- Eliminate the requirement to use certified EHR technology to document communication with home- and community-based providers regarding the beneficiary’s psychosocial needs and functional deficits.

CMS also proposes to cover more complex and time-intensive CCM services by adopting CPT codes 99487 and 99489. These codes would have the same billing requirements as the existing CCM code, and therefore could only be reported once per calendar month by one practitioner who provides care management for the beneficiary in that month.
MGMA comment: MGMA has long supported efforts to add Medicare services that enable practices to better provide high quality, coordinated care to Medicare beneficiaries. Services such as CCM are a step in the right direction for enhancing Medicare beneficiary care management and preventing adverse events, such as unnecessary hospital readmissions. Many practices have long been providing this type of care coordination without receiving reimbursement. By recognizing and reimbursing for these services, CMS allows practices to enhance their focus on care coordination. Unfortunately, however, many practices have been prevented from receiving reimbursement for them as a result of burdensome administrative requirements to be eligible to furnish these services. We are pleased CMS has proposed to revise or remove a number of requirements for these services to allow more practices to provide them to Medicare beneficiaries, and we urge the agency to finalize these proposed improvements.

To further improve access to these services and remove barriers to billing CCM, MGMA urges CMS to make two additional modifications to the CCM scope of service requirements. First, the agency should provide additional flexibility to obtain beneficiary consent by removing the requirement to obtain consent as part of a face-to-face visit, including an Annual Wellness Visit, Initial Preventive Physical Examination or face-to-face E/M service. While CMS proposes to remove the required initiating visit for patients who have been seen within the last year, we believe the agency should expand upon this proposal by removing this requirement for all patients. The conversation initiating CCM and discussing beneficiary consent could easily be done over the phone where a care coordinator would walk the patient through the beneficiary consent form, after which the patient could either mail a signed copy of the form, or log into an online patient portal to provide their consent. Ultimately, there could be a variety of ways in which an Accountable Care Organizations (ACOs) or practices could adequately explain the service and discuss beneficiary consent. CMS should provide flexibility to those who may have creative ideas for how to engage patients and begin furnishing CCM. Consequently, we urge CMS to remove the face-to-face requirement for obtaining beneficiary consent.

Second, CMS should remove the requirement that CCM services be furnished using, at a minimum, the edition(s) of certification criteria acceptable for the EHR Incentive (meaningful use) Program as of December 31 of the calendar year preceding each CCM payment year. Purchasing and implementing an EHR demands considerable financial and administrative resources, and a high-quality EHR may serve an organization’s needs for many years, even if it is not certified to the most recent CMS certification criteria. While an EHR can be an asset to furnishing this service, it is unfortunate to prevent beneficiaries whose providers do not meet specific EHR certification requirements from accessing CCM services. We urge CMS to remove the requirement for a specific level of EHR certification.

MGMA also supports expanded Medicare coverage for high-severity CCM services, as patients with complex chronic needs often require intense and prolonged care coordination efforts to prevent adverse events, such as preventable inpatient admissions and readmissions. We urge CMS to finalize its proposal to adopt CPT codes 99487 and 99489 and recommend CMS adopt the same scope of service requirement modifications as proposed for CPT code 99490.
**Appropriate Use Criteria (AUC) for diagnostic imaging**

**CMS proposal:** Under the Protecting Access to Medicare Act, CMS is required to identify mechanisms for consultation with AUC by Apr. 1, 2016 and begin mandating the use of AUC by both ordering and furnishing professionals on Jan. 1, 2017. This year, CMS proposes to set up AUC for eight priority clinical areas identified by the agency in addition to requiring the use of AUC for all diagnostic imaging, define the requirements of clinical decision support mechanisms (CDSMs) and establish exceptions for ordering professionals for whom consulting AUC would pose a significant hardship. The agency notes that it will not meet the statutory timeline requiring ordering and furnishing professionals to consult qualified CDSMs by Jan. 1, 2107, but anticipates professionals must comply with the AUC requirements as early as Jan. 1, 2018.

**MGMA comment:** We continue to have ongoing concerns about the administrative and financial burdens practices will face when trying to comply with new AUC requirements. First and foremost, this proposal will impact physician practices at the same time the new MIPS takes effect, and will at times require duplicative work. For example, CMS discusses the identification of outliers using AUC; however, the resource use component of MIPS addresses outliers and therefore, the use of AUC for outlier identification is superfluous. The timeline for AUC has already been pushed back, and we urge CMS to delay implementation of the AUC program until after MACRA has been implemented to avoid duplicities and not overwhelm providers during what is already a period of massive transition.

Secondly, this proposal will allow CDSMs to either be incorporated into EHRs or be stand-alone applications. Stand-alone applications could pose both workflow and interoperability issues for practices. These stand-alone applications will create an enormous administrative burden on practices, as duplicative data entry would be required. Additionally, we have concerns that the supporting vendors and applications will not be ready in time to begin this program, especially because EHR vendors will be focusing their efforts on preparing for the new requirements under MIPS. In addition, the industry continues to face challenges related to effective and efficient data interoperability. These new CDSMs will pose a significant financial burden on practices to update EHRs or implement stand-alone applications at the same time they are preparing and upgrading systems to interoperate with other care settings, as well as meet the numerous technology requirements under MACRA.

The agency’s proposal to require AUC for all advanced diagnostic imaging, including those not in the priority clinical areas, will require practices to attain CDSMs for all advanced diagnostic imaging services, even as CDSMs are not required to have any AUC other than those in the priority clinical areas. This will lead to practices having to purchase and use more than one CDSM to ensure that all bases are covered. In addition to the financial burden, this will increase administrative burden as clinicians will be required to consult multiple CDSMs, even for those not in priority clinical areas.

In conclusion, we strongly urge CMS to delay the implementation of the AUC provisions until MACRA is entirely implemented, AUC requirements are completely aligned with MACRA and CDSMs have been tested and are interoperable with EHRs.

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Open Payments Program: Reports of payments or other transfers of value to covered recipients

CMS proposal: CMS solicits feedback on several topics from stakeholders to inform future rulemaking on the Open Payments Program, including input on how to improve the payment review and dispute process.

MGMA comment: We believe that this program can be more accurately utilized and accessed by practices and physicians with some changes to the reporting process. The current process of providing a once-a-year review and dispute is onerous and requires practices and physicians to meet an arbitrary deadline while simultaneously fulfilling reporting requirements for other CMS programs. MGMA recommends CMS allow information to be reviewed and disputed throughout the year by physicians and practice administrators. In addition, MGMA recommends a notification be sent to the email address on file for the physician or practice administrator when an applicable manufacturer reports a transfer of value. This would allow the physician or practice administrator to review and dispute the report almost instantaneously. Data would be more accurate because practices would be able to track transfers of value as they happen and would prompt the physician or practice administrator to access the system on a more regular basis.

Recoupment or offset of payments to providers sharing the same tax identification number (TIN)

CMS proposal: CMS proposes to clarify its notification process for overpayments that may be recouped or offset. Specifically, in cases where there are multiple entities sharing the same TIN, each would be liable for the overpayment, although CMS would only notify the entity responsible for the overpayment.

MGMA comment: MGMA believes CMS would be doing itself a favor by requiring contractors to notify all provider entities from which it might try to recoup an overpayment. Otherwise, those who have not been notified may not immediately understand the cause when claims are denied and could reasonably call, write, and appeal the denial until all affected entities are made aware of the overpayment.

Medicare Advantage (MA) provider enrollment

CMS proposal: The agency makes a number of proposals related to MA, including requiring physicians to be enrolled in Medicare in order to provide services and contract with MA organizations (MAOs). If a physician is not enrolled in Medicare with an approved status, the MAO could face sanctions including contract termination. Additionally, CMS proposes to prohibit MAOs from paying providers that are excluded by the Office of Inspector General or revoked from the Medicare program. The MA organization would be required to notify the beneficiary whose services were not covered in writing that no future payment will be made to the provider.
MGMA comment: While we understand that this proposal aligns with the agency’s broader program integrity initiatives, we believe that CMS should engage in robust provider and practice education to ensure enrollment updates are implemented efficiently and without complication.

Expansion of the Diabetes Prevention Program (DPP) model and reimbursement for diabetes self-management training (DSMT)

CMS proposal: CMS proposes to expand the DPP into Medicare beginning Jan. 1, 2018 and to refer to the new model as the Medicare Diabetes Prevention Program (MDPP). CMS outlines the framework for the MDPP, which would allow DPP organizations recognized by the Centers for Disease Control to submit claims for payment tied to beneficiary educational sessions and achievement of weight loss goals. MDPP would be available to pre-diabetic beneficiaries CMS proposes to allow DPP organizations to provide MDPP services in-person or virtually using remote technology. CMS seeks comment on whether the program should be rolled out nationally or phased in, which would allow the agency time to refine technical issues prior to broader model scaling.

CMS also seeks input on ways to eliminate barriers to access of DSMT services, which are intended to educate beneficiaries in successful self-management of diabetes. Recent research found that only 5% of Medicare beneficiaries with newly diagnosed diabetes used DSMT services.

MGMA comment: MGMA supports expanding the DPP in an effort to enhance beneficiary care and outcomes related to pre-diabetes and particularly urges CMS to allow these services to be furnished on a virtual basis to ensure beneficiaries who may have difficulty driving or finding transportation to the practice are able to benefit from these services. However, CMS must provide additional details regarding how these services would be furnished in a physician office setting to allow stakeholders to properly comment prior to expansion in 2018. For instance, it is unclear whether physicians and group practices who undergo an in-depth Medicare enrollment process to participate in and bill Medicare for services they furnish would be expected to achieve the same Centers for Disease Control and Prevention certification as non-Medicare entities. MGMA would strongly oppose this requirement as duplicative of Medicare’s stringent program integrity efforts.

The proposed MDPP reimbursement schedule is too low for group practices who have more significant costs, such as practice expenses including medical office rent, supplies, equipment and support staff. MGMA recommends increasing reimbursement rates. We also urge CMS to limit documentation and billing requirements, which are often a hindrance to providers participating in similar programs, such as CCM.

In addition to a modified and expanded DPP applicable to Medicare providers, we urge CMS to align pre-diabetes education codes and billing requirements with established Medicare diabetes self-management education and training services and increase reimbursement for these services.
Value-Based Payment Modifier (VM) redeterminations in cases where unanticipated issues arise

CMS proposal: CMS proposes to codify in rulemaking how VM quality and cost scores would be affected for the 2017 and 2018 payment years in cases where widespread data accuracy concerns arise, or when an individual practice’s informal review request overturns the status of its VM determination. In the event that a widespread claims issue renders quality data unusable, affected groups would be automatically designated as having “average quality” and would retain their original cost determinations, with the exception that groups designated as “high cost” would be reclassified as “average cost” to avoid a negative adjustment without sufficient, scoreable quality data. Similarly, in scenarios where widespread calculation errors are discovered after the quality resource and use reports are released, practices with low quality or high cost composites would be automatically reclassified as “average.”

Should a practice’s automatic VM penalty designation be reversed following an informal review, CMS proposes to evaluate quality and cost composite scores differently based on whether the practice’s providers reported PQRS measures as individuals or collectively through the group practice reporting option (GPRO). Groups reporting under the GPRO would automatically receive an average quality score, regardless of actual performance, while cost would be calculated from the claims as normal, except groups receiving a “high cost” designation would be reclassified as having “average cost.” For practices whose providers elect to report as individuals, both cost and quality composite scores would be retained as originally calculated without incorporating data from any newly applicable EPs. However, “low quality” marks would be rescorded as “average” to avert a penalty.

MGMA comment: Overall, MGMA supports CMS recognizing the need for transparent, predictable expectations for VM payment determinations. In the past, decisions in these scenarios were rendered on a case by case basis with little explanation. MGMA has long advocated for the importance of holding physician practices harmless from penalties resulting from errors made by external parties, and we urge CMS to finalize its proposals to take this approach in the last two years of this program.

However, we are concerned that practices would have no opportunity to resubmit data or have their composite scores recalculated to reflect all available data. While we appreciate that recalculating VM composite scores can be “operationally complex” for the agency, substantial financial and administrative investments often go into reporting data for these programs, and physician practices should not be deprived of potential incentive payments they have rightfully earned at the last minute because measures were reported or calculated inaccurately through no fault of their own.

We urge the agency to recalculate cost and quality determinations following a reversal of a VM determination for any group practices who request a redetermination of their data. The actual number of these cases is likely to be small, thus placing minimal operational burden on CMS. However, the implications on an individual practice could be great.
Further, we urge the agency to offer practices an opportunity to resubmit quality data through another reporting mechanism when feasible in cases where widespread data accuracy issues render quality data unusable. Again, we expect the number of instances in which this would occur to be small, but reiterate the importance of not closing the door on physician practices who put in a great deal of time and effort into participating in federal quality reporting programs.

**Medicare Shared Savings Program (MSSP)**

**CMS proposal:** In general, the agency proposes a number of technical corrections to accommodate MSSP ACOs under the forthcoming transition to MIPS and APMs under MACRA. Under separate proposals included in the “Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule (PFS), and Criteria for Physician-Focused Payment Models; Proposed Rule,” released on May 5, 2016 (“MIPS/APMs proposed rule”), MSSP ACOs in Tracks 2 or 3 would be considered advanced APMs and thereby eligible for the various incentives allotted for qualified APMs under MACRA. Track 1 MSSP ACOs would be deemed MIPS APMs – a designation that would render them ineligible for the advantages of the APM track and necessitates participation in MIPS, where they would qualify for preferred scoring and alternative weighting of performance categories. In anticipation of ACO participation in MIPS, CMS proposes to modify the EHR measure for MSSP ACOs (ACO Measure 11) to assess ACOs on the degree of certified EHR technology used by all providers and suppliers participating in the ACO, as opposed to strictly primary care physicians.

**MGMA comment:** MGMA reiterates its position, outlined in detail in our letter responding to the MIPS/APMs proposed rule, that all MSSP ACOs should be considered eligible APMs and substantially participating group practices in these ACOs should be exempt from MIPS. We understand, however, that there will be overlap between APMs and MIPS, as practices may fall short of the Qualified Participant (QP) threshold and therefore default into MIPS. We continue to urge the agency to provide sufficient flexibility for these practices, so they may continue to focus their efforts on transforming their care delivery models to succeed in the APM without simultaneously juggling the reporting requirements of MIPS.

We also oppose CMS’ proposed changes to ACO Measure 11. MGMA believes this measure is currently sufficient to meet the advanced APM criteria included in the recent MIPS/APMs proposed rule and that during this time of major transition the agency should seek every possible opportunity to maintain stability in measures. Further, an ACO’s patient attribution is based on primary care providers’ services; therefore, evaluating the percent of primary care providers using Certified Electronic Health Record Technology in the ACO is sufficient to meet the advanced APM EHR use standard proposed by CMS. Should CMS finalize its proposal to modify this measure specification to assess the ACO on all clinicians’ performance under Advancing Care Information (ACI) requirements, at a minimum, those Eligible Clinicians (ECs) who are excluded from ACI requirements under MIPS should also be excluded from the denominator of ACO Measure 11.
Finally, the EHR reporting proposals under MIPS would significantly deviate from the current EHR reporting requirements under Meaningful Use, and would thus take substantial time and effort to operationalize. Therefore, we urge CMS to make ACO Measure 11 pay for reporting for all three performance years to provide sufficient time to transition to the new ACI reporting requirements.

We appreciate your consideration of these comments. If you have any questions, please contact me at 202.293.3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs