



Sept. 7, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Administrator Verma:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the proposed rule entitled, “Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program,” published on July 27, 2018, with file code CMS–1693–P.

MGMA is the premier association for professionals who lead medical practice. Since 1926, through data, people, insights, and advocacy, MGMA empowers medical group practices to innovate and create meaningful change in healthcare. With a membership of more than 40,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 organizations of all sizes, types, structures and specialties that deliver almost half of the healthcare in the United States.

Key Recommendations

MGMA supports CMS’ “Patients over Paperwork” Initiative, which the agency launched to reduce regulatory burden on physician practices who care for Medicare patients. We have made detailed recommendations below to assist CMS in achieving its stated goals of reducing clinician burden and improving patient care. MGMA highlights the following regulatory relief priorities for medical groups:

1. **Reconsider options for reducing documentation associated with E/M office visits without harming physician practices that treat the sickest patients.** We urge CMS not to move forward with its proposal to collapse payment rates for eight office visits for new and established patients down to two each as there are many unanswered questions and potential unintended consequences that would result.
2. **Promote access to care by providing reimbursement for communications-based technology and telehealth services.** CMS should modernize the Medicare program by finalizing coverage for virtual care, interprofessional consultation, and remote patient monitoring services. To facilitate widespread adoption of new non-face-to-face services, CMS

should permit practices the flexibility to implement any new covered codes in a manner that best fits their practice and avoid overly restrictive billing requirements.

3. **Do not restrict the use of drugs in physician offices by finalizing the proposal to reduce Medicare reimbursement for new drugs from Wholesale Acquisition Cost (WAC) + 6% to WAC + 3%.** This proposal would hinder Medicare patients' access to new and innovative therapies that are more effective or less debilitating than existing drugs in a less expensive site of service: the physician office.
4. **Make the Appropriate Use Criteria program (AUC) voluntary in 2020 and beyond,** provide free Clinical Decision Support Mechanism software, and focus on education for professionals who order advanced diagnostic imaging services.
5. **Permanently shorten the minimum Merit-based Incentive Payment System (MIPS) reporting period to any 90 consecutive days** using sampling and attestation methodologies to ensure statistical validity. Participants should have the option to report more data as needed.
6. **Decrease MIPS reporting requirements.** Physician group practices' finite resources would be spread across at least 16 measures, including a minimum of six quality measures, two cost measures, six Promoting Interoperability measures, and two improvement activities in 2019. CMS should structure MIPS to allow practices to prioritize effective and impactful improvements to patient care, rather than comply with sprawling reporting mandates.
7. **Simplify MIPS and reduce redundancies by awarding multi-category credit.** As implemented, MIPS reflects a continuation of the agency's historically siloed approach to quality reporting, consisting of four programs under one umbrella. To reduce burden, CMS should award credit in multiple categories for overlapping efforts, such as using clinical-decision support or capturing patient-reported outcomes.
8. **Provide clear and actionable feedback about MIPS performance at least every calendar quarter,** as recommended by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Without timely, detailed feedback, MIPS is essentially a reporting exercise that enters data into a "black box" only understood by CMS, rather than a useful barometer practices can leverage to drive clinical improvement.
9. **Increase opportunities to participate in Advanced Alternative Payment Models (APMs).** CMS should consider the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration a pathway to Advanced APM status and implement the physician-led APMs proposed by front-line providers and recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC).
10. **Permit MIPS and APM participants to use 2014 or 2015 Edition Certified EHR Technology (CEHRT) in 2019 and 2020.**

Evaluation and Management (E/M) Services

As Medicare transitions from fee-for-service toward a value-based system and physicians take on more accountability for their resource use, the cognitive care furnished during E/M services—often the bedrock for the physician-patient relationship—has increasing importance. MGMA agrees there is significant opportunity to eliminate needless documentation requirements for billing an E/M visit code.

However, we have significant concerns with the proposed collapse of E/M codes and urge CMS not to finalize this proposal. Instead, CMS should engage stakeholders, including physician practice leaders, in a transparent process to achieve our shared goal of reducing burden in the E/M guidelines. To assist CMS as it explores opportunities to revise E/M documentation guidelines to reduce burden and modernize patients' medical records, MGMA has developed a set of principles that are woven throughout our comments below and included in their entirety as Appendix A.

E/M payment rate and relative value unit (RVU) collapse

CMS proposal (83 Fed. Reg. 35839): CMS believes the system of 10 codes for new and established office visits is “outdated” and proposes to retain but revise and simplify the codes and their reimbursement by applying a single, blended payment rate for level 2 through 5 office visits. CMS would establish a single set of RVUs for E/M office-based and outpatient visits levels 2 through 5 for new patients (CPT codes 99202-99205) and established patients (CPT codes 99212-99215).

“[P]ractitioners would still bill the CPT code for whichever level of E/M service they furnished, and they would be paid at the single PFS rate. However, [CMS] believe[s] that eliminating the distinction in payment between visit levels 2 through 5 will eliminate the need to audit against the visit levels, and therefore, will provide immediate relief from the burden of documentation.”

MGMA comment: MGMA opposes the proposal to collapse payment and RVU amounts for levels 2 through 5 for new patients and established patients for the reasons outlined in detail below. Instead, we urge CMS to work closely with the physician community to analyze E/M coding and payment issues to arrive at workable solutions to reducing documentation burden. MGMA supports the American Medical Association work group of physicians and other health care professionals, which is already discussing alternatives to the proposal in a transparent and open manner. As part of this effort, we emphasize our belief that burden reduction will be a product of developing clearer distinctions between levels of the descriptions for office visits. Because the work of creating these distinctions will not be easy, we urge careful consideration of any unintended consequences. We also caution against other policy short-cuts, which is how we would characterize this proposal to merely collapse the distinctions altogether and replace them with ambiguous add-on payments.

We believe the proposal to treat all office visits the same, regardless of a patient's condition or the complexity of the services provided, is misguided. We surveyed MGMA members and received significant feedback outlining concerns that the proposal would underpay doctors who care for patients with the greatest medical needs and most complex conditions. Many medical practices suggested they would reduce their Medicare patient volume or limit the medical issues addressed during one office visit, which could hinder access to care and create inconveniences and expenses for Medicare beneficiaries.

Articulating a common reaction among medical group leaders and clinicians, one survey respondent wrote, “Family Medicine is being pushed to provide more and more services. While we are working to save the system money, adding AWWs and complex management services, CMS proposes to punish us for seeing complex patients and doing as much as work as possible for a beneficiary. We will have to move to require Medicare patients to come back to a series of visits to take care of all their needs.” Another respondent wrote, “There must be some differential associated with the payment for more complex services. Going to one fee for levels 2-5 would mean that a patient with a r/o ear infection or UTI would receive the same reimbursement of patients being worked up for pancreatic cancer, major surgical procedures. This would discriminate against specialists who see very sick, complex patients. Their malpractice risks/premiums increase based upon complexity of specialty (i.e., ENT vs Vascular

Surgery) and all of the methodology going into costs were studied and implemented into RBRVS to account for these differences.”

The Association also has reason to doubt the agency’s belief that eliminating the distinction between visit levels 2 through 5 would eliminate the need to audit against the visit levels given the absence of any substantive guidance regarding whether the Medicare auditors, including the Office of Inspector General and Recovery Audit Contractors, would follow this instruction. Presumably, there would be some scrutiny of a medical service if billed as a level 5 but documented as a level 2. Prior to moving forward on the unsubstantiated belief that audits would be eliminated, CMS should provide assurance and clarification from the Department of Health and Human Services that auditors would, in fact, recognize this level of medical documentation as sufficient evidence of the medical necessity of an office visit if documented to the standards CMS adopts.

Setting the issue of audits aside, we see several gaps in the agency’s logic that the proposed payment rate and RVU collapse would “provide immediate relief from the burden of documentation.” First, and most importantly, the purpose of the medical record is to promote quality and continuity of patient care. At its core, documentation should reflect clinical findings and knowledge that can facilitate the best possible treatment of a patient. To this end, allowing clinicians to focus on caring for patients and not ticking documentation boxes is a laudable goal. However, we have concerns that relying on nebulous medical necessity guidelines and bare bones medical decision-making documentation will result in an inferior medical record and create problems when patients transition from one provider or care setting to another. Further, much of the over-documentation can be attributed to ambiguity in the existing medical documentation guidelines. Although we appreciate the agency’s efforts to provide greater flexibility to uncuff providers from their computers and to provide better care, we have reason to believe the lack of clarity around documentation requirements would do little to address the ambiguity driving much of the over-documentation.

Second, CMS itself states that physicians and other practitioners would continue to code, and thus document, according to the CPT level appropriate for the visit, suggesting little change in practice. Although we discuss the proposed add-on services and payment amounts in more detail below, we believe that documenting appropriately for the level of care furnished, as well as for the add-on payment, would likely result in a net increase to documentation requirements compared to the status quo.

Third, the payment rate and RVU collapse proposal fails to address other factors driving over-documentation, such as quality measurement requirements, prior authorization requests, risk adjustment considerations, and medical liability concerns. CMS acknowledges that “[p]ractitioners could choose to document more information for clinical, legal, operational or other purposes, and we anticipate that for those reasons, they would continue generally to seek to document medical record information that is consistent with the level of care furnished” (83 Fed. Reg. 35836). Without addressing these broader factors, CMS’ proposal will do little to alleviate the “note bloat” associated with over-documentation.

Finally, CMS assumes other payers, including Medicaid and commercial plans, would follow in their direction, collapse the payment rates and RVUs for the E/M office visits and thus reduce documentation. Although payers may be inclined to adopt the lower reimbursement amounts proposed in this rule, we think it is unlikely that they would adopt the documentation changes in their entirety. Medicaid and commercial payers currently employ a wide spectrum of policies to interpret medical necessity. Further, we believe the proposed guidelines are not clear and comprehensive enough to be implemented immediately by other payers, suggesting there would be at best a short window during

which physician practices would need to abide by multiple different documentation requirements depending on their patients' insurance coverage. This is not sustainable.

E/M multiple procedure payment reduction

CMS proposal (83 Fed. Reg. 35841): CMS proposes to reduce payment by 50% for the least expensive procedure or visit that the same physician (or a physician in the same group practice) furnishes on the same day as a separately identifiable E/M visit, currently identified on the claim by an appended Modifier 25.

MGMA comment: MGMA urges CMS not to adopt the proposed policy of reducing payment by 50% for the least expensive procedure or visit performed on the same day as an E/M service. We believe CMS needs to further 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 or other medically necessary visit, such as an Annual Wellness Visit. The use of Modifier 25 indicates the E/M service is medically significant and separate from the additional service. The RVS Update Committee (RUC) has worked diligently along with national medical specialty societies and other health care professionals to ensure there are no duplicate resource costs embedded in procedure costs typically performed with E/M services.

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.

E/M add-on payments

CMS proposal (83 Fed. Reg. 35842): CMS proposes to create two new add-on payments related to E/M services. The first, GPC1X, would be for visit complexity inherent to E/M associated with primary medical care services provided to established patients that serve as the continuing focal point for all needed healthcare services. CMS also proposes to create a HCPCS G-code "to be reported with an E/M service to describe the additional resource costs for specialty professionals for whom E/M visit codes make up a large percentage of their overall allowed charges and whose treatment approaches we believe are generally reported using the level 4 and level 5 E/M visit codes rather than procedural coding." This code, GCG0X, would reimburse for visit complexity inherent to E/M management "associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care."

MGMA comment: We have significant reservations about the lack of clarity around these proposed add-on codes and the rationale for their proposal. Our understanding is that these add-on payments were proposed, at least in part, to mitigate a redistribution of funding from certain specialties to others. We have concerns about the analysis that went into this decision, as we have received estimates from MGMA members and other stakeholders suggesting CMS' impact analysis is not fully reflective of the payment redistributions that would result from the proposed E/M payment changes.

To fully evaluate the impact of these add-on payments, MGMA requests clarification regarding the following frequently asked questions we have received from members regarding the proposed add-on codes:

- Are these G-codes limited to the enumerated specialties included in the new code descriptions?

- How did CMS arrive at the specialties enumerated in the new code descriptions?
- If a physician provides care related to one of those specialty designations but is not designated in Medicare as one of those specialties, can he or she bill the add-on code?
- Can a physician bill both GPC1X and GCG0X during the same visit if the service involves both ongoing primary care and care associated with pain management, for instance?
- Why are psychiatrists expressly prohibited from using the add-on codes?
- Does GCG0X apply to services related to sub-specialties affiliated with the enumerated specialties? For instance, there are many sub-specialties of cardiology, including several that have a procedure-based clinical focus. Would all subspecialists be eligible to bill GCG0X?
- Did CMS consider alternatives to supplementing payment for care of complex patients?

Moreover, we have concerns about the lack of documentation details for billing either GPC1X or GCG0X. Did the agency account for the additional documentation associated with these add-on payments when estimating the overall burden reduction associated with E/M visits? Given the improbability that there will be no documentation associated with these add-on payments, we believe they may increase the overall documentation burden relative to current E/M coding and documentation.

Implementation timeline

CMS proposal (83 Fed. Reg. 35848): The proposed implementation date for E/M changes is Jan. 1, 2019. CMS also seeks comment on whether the implementation should be delayed to Jan. 1, 2020.

MGMA comment: MGMA strongly opposes implementation of the proposed E/M payment changes on Jan. 1, 2019. Prior to moving forward with any proposed E/M payment changes, CMS must ensure it has sufficiently addressed all concerns and outstanding questions regarding how these changes would impact physician practices and mitigate against unintended consequences.

If CMS does move forward with either a 2019 or 2020 start date, we urge the agency to establish a significant grace period during the transition from the current guidelines to the new documentation requirements. Physician practices should not be audited or penalized while they are implementing the new documentation guidelines. The transition from ICD-9 to ICD-10 could serve as an illustrative example of an appropriate grace period during the transition. Further, CMS should undertake a comprehensive education and outreach campaign to inform practitioners and medical practice leaders about E/M documentation changes.

E/M documentation changes

CMS proposal (83 Fed. Reg. 35835, 35838): CMS proposes the following changes to E/M documentation:

- Rather than redocument a defined list of required elements such as review of a specific number of systems and family/social history, practitioners would only need to document what has changed since the last visit or on pertinent items that have not changed;
- For both new and established patients, practitioners would no longer be required to re-enter information in the medical record regarding the chief complaint and history that are already entered by ancillary staff or the beneficiary; and
- Practitioners would no longer be required to document the medical necessity of furnishing the visit in the home rather than in the office.

MGMA comment: MGMA supports CMS' "Patients over Paperwork" Initiative and agrees there are opportunities to reduce administrative burden and better align E/M documentation guidelines with the

current practice of medicine. We urge the agency to adopt the three proposed documentation changes above, as we believe they will streamline documentation requirements, improve work flow and better reflect the team-based care approach of group practices. However, we again reiterate our opposition to the proposed changes that would collapse E/M payment and RVU amounts.

Modernizing Physician Payment through Communication Technology-based Services

CMS proposal (83 Fed. Reg. 35722): CMS proposes a number of payment changes designed to increase coverage for communication technology-based services. The agency communicates a new interpretation that certain services are inherently furnished using communications technology and should not be considered “telehealth” services within the meaning of Section 1834(m) of the Social Security Act. Rather, Section 1834(m), which imposes reimbursement limitations on telehealth coverage, applies to a discrete set of services that are defined, coded, and paid for as if they were furnished in an in-person encounter.

In light of this interpretation, CMS proposes to pay separately for newly defined types of physician services furnished using communications technology that fall outside the statutory definition of Medicare “telehealth” services.

Starting Jan. 1, 2019, CMS would provide reimbursement for brief non-face-to-face appointments, or virtual check-ins, between an established patient and a physician or other qualified health professional (HCPCS code GVC11). CMS seeks comment on various aspects of this service, including the types of technologies (e.g., audio-only communications) that may be appropriate for virtual visits, whether to require patient consent to such services, how to document medical necessity, and whether to impose a frequency limitation.

CMS proposes a new code to describe the remote evaluation of patient-transmitted information conducted via “store and forward” video or image technology using HCPCS code GRAS1. The agency seeks feedback on the description, coverage, and valuation.

In addition, CMS proposes to value new CPT codes for Interprofessional Internet Consultation (994X6, 994X0) while also proposing to unbundle and provide separate payment for existing CPT codes (99446, 99447, 99448, and 99449). The addition of interprofessional consult codes would cover consultations between professionals performed via technology such as telephone or internet, for the benefit of treating a patient. CMS requests input on how to minimize potential program integrity concerns and the assumption that these are separately identifiable services distinguishable from consultations rendered for the benefit of the practitioner.

MGMA comment: To further support healthcare delivery and payment reform, it is critical that physicians, medical group practices, patients, and other stakeholders have sufficient flexibility to utilize communications-based modalities as a tool for expanding patient access to quality care that is cost-effective. MGMA supports the agency’s important step in the right direction toward recognizing practitioners for patient care efforts that occur outside of the traditional office visit. Digital medicine offers group practices increased opportunity to connect with patients and engage them in shared decision-making and management of chronic conditions and better coordinate care using a team-based approach to medicine.

As CMS has taken an approach that more narrowly defines the types of physician services envisioned by Section 1834(m), digital health services that fall outside the statute’s definition of “telehealth” services would not be subject to its geographic and originating site limitations. As with remote patient

monitoring (RPM) services, this means CMS has significant discretion to expand coverage of services inherently furnished using communications technologies.

In response to CMS' request for feedback on the types of technologies that should qualify for the new virtual check-in code (HCPCS GVC11), MGMA recommends that CMS include audio-only telephone interactions, as well as secure electronic communications, as qualified communication modalities. A secure electronic communication sent via e-mail, patient portal, or a mobile application, should qualify so long as HIPAA security standards are met. Allowing virtual care check-ins to occur via EHR, patient portal, or other similarly situated electronic communication is in-line with CMS' policy to encourage EHR use and increase access to patient portals. We urge CMS to finalize both HCPCS GVC11 and HCPCS GRAS1 and encourage CMS to work with the CPT Editorial Panel to develop appropriate codes and to adopt such codes when available.

In the context of interprofessional internet consultation codes, MGMA appreciates CMS' support of a team-based approach to care and for recognizing that care coordination can be facilitated via electronic medical record technology. Peer-to-peer consultation is an important tool in the shift toward comprehensive, patient-centered care management and can be particularly useful in managing the care of patients with chronic conditions.

While we are supportive of CMS' proposals to cover additional communications-based services, we urge CMS to avoid imposing overly burdensome billing requirements that could impede widespread adoption of newly defined virtual care, store and forward, and interprofessional consultation codes and additional RPM codes (collectively, digital medicine services). In the past, administrative requirements associated with other newly recognized services, such as chronic care management (CCM) codes, have prevented group practices from being eligible to receive reimbursement for care management efforts.

In discussions with MGMA members, we heard practices would be hesitant to bill new digital medicine services if codes contained similar administrative billing requirements for eligibility as CCM services. With CCM, although the agency has made numerous improvements to the requirements for billing this service, MGMA members have identified ongoing issues including difficulty collecting cost-sharing amounts; patient confusion regarding cost-sharing obligations for care furnished remotely; and a lack of adequate education materials to inform staff of billing guidelines.

To avoid imposing the same barriers to reimbursement for new digital medicine codes, MGMA urges CMS to limit documentation and billing requirements and provide comprehensive education on furnishing these new services following the publication of the final rule. In order to begin offering a new service, it often takes months for a practice to design new processes and work flow, as well as train and educate staff. Uncertainty relating to documentation requirements or specific elements of services may limit adoption of these new technologies, which in many cases require up-front capital, which could in turn limit beneficiary access to the new services. We urge CMS to work collaboratively with MGMA and others from the physician community to produce timely, thorough education and resources.

For newly covered codes that require beneficiary consent, MGMA supports CMS proposals to permit group practices to obtain verbal consent, such as over the phone when furnishing the service. The conversation initiating a virtual care visit and discussing beneficiary consent could easily be done over the phone. Ultimately, there could be a variety of ways in which medical group practices could adequately explain the service and discuss beneficiary consent remotely. To the extent that a digital medicine service is furnished using electronic communications rather than a telephone, consent provided in an electronic format should be sufficient.

Lastly, we also encourage CMS to explore avenues within its statutory authority or seek expanded authority to eliminate the patient cost-sharing element of digital medicine and similar care management services. Billing co-payments for these services risks creating confusion as beneficiaries are not accustomed to paying for services without a face-to-face component, and it is difficult to explain the return on investment through timely care interventions that may prevent more costly hospital or emergency department visits down the road. In addition, the administrative costs of monthly collections may deter some practices from billing this service altogether.

Medicare Clinical Laboratory Fee Schedule (CLFS) Data Collection

Revised definitions of applicable laboratory and low volume expenditure

CMS proposal (83 Fed. Reg. 35849, 35855): Starting Jan. 1, 2018, CMS implemented a new payment methodology for clinical laboratory testing paid under the CLFS using a market-based methodology, as required under section 216 of the Protecting Access to Medicare Act (PAMA) of 2014. Payment rates under the CY 2018 CLFS are based on private payer pricing data collected and reported by “applicable laboratories.” For most CLFS tests, PAMA requires that the data collection period, data reporting period, and payment rate update occur every three years. As such, the next data collection period for applicable laboratories is set for Jan. 1 through June 30, 2019, the next data reporting period is set for Jan. 1 through Mar. 31, 2020, with the next CLFS update occurring on Jan. 1, 2021.

As defined in 42 CFR 414.502, an “applicable laboratory” is: accredited under the Clinical Laboratory Improvement Amendments (CLIA) of 1988; bills Medicare Part B under its own National Provider Identifier (NPI); and, during a data collection period, the lab NPI receives more than 50 percent of its Medicare revenues from the CLFS and/or the PFS [“majority of Medicare revenue threshold”] and receives at least \$12,500 of Medicare revenues under the CLFS [“low expenditure threshold”]. In establishing these criteria, CMS intended to achieve a balance between collecting sufficient data and minimizing the reporting burden for entities.

CMS proposes just one change to laboratory payment policies for CY 2019: the agency would amend the definition of applicable laboratory to revise the way Medicare Advantage (MA) payments are treated such that additional laboratories serving high populations of MA beneficiaries would be subject to reporting requirements.

CMS also requests feedback on potential revisions to the applicable laboratory definition that could impact the entities that qualify for reporting. Specifically, CMS seeks input on whether to increase or decrease the low expenditure threshold by 50% and whether to identify laboratories using an identifier other than an NPI, such as the CLIA certificate or Form 1450x bill type.

MGMA comment: MGMA has significant concerns regarding CMS’ implementation of PAMA’s laboratory payment reform provisions, which we have repeatedly pointed out throughout the implementation process. Unfortunately, the proposed rule does little to ameliorate or even address most of our concerns, including that the implementation pathway chosen by CMS is threatening the viability of in-office laboratories that provide critical point-of-care testing to Medicare beneficiaries.

CMS misses the mark in its commentary on the CLFS and conveys an incomplete understanding of the issues voiced consistently by MGMA and other stakeholder groups. The single proposed revision, to adjust the treatment of the majority of Medicare revenue threshold and focus on adjusting the applicable laboratory definition, does not convey a serious effort to resolve fundamental issues with PAMA implementation.

CMS does acknowledge two stakeholder concerns; namely: (1) physician office laboratories (POLs) and small laboratories are not prepared to collect and report data and meeting data collection and reporting obligations constitutes an extraordinary burden, and (2) the data used to formulate CY 2018 CLFS rates did not adequately represent the national laboratory market.

Unfortunately, to the latter point, CMS does not agree with this concern (“we are confident that our current policy supports our collecting sufficient applicable information in the next data reporting period, and that we received sufficient and reliable applicable information with which we set CY 2018 CLFS rates, and that those rates are accurate” [83 Fed. Reg. 35859]). This is confounding, considering that MGMA and others have conveyed to CMS known reports of laboratories inadvertently submitting inaccurate or incomplete data. Worse, 90% of the data used to formulate the CY 2018 CLFS rates came from independent laboratories,¹ yet CMS estimates that only 1% of NPI-level entities enrolled as a laboratory are enrolled as an independent laboratory (93% are enrolled as a POL).² This limited data therefore does not adequately represent the laboratory market.

To address these concerns, CMS considers either raising the low expenditure threshold to exclude additional POLs from reporting obligations or decreasing the low expenditure threshold to increase POLs that report data. This suggests the Choosing one of these options over the other comes at the expense of exacerbating the negative consequences of another underlying issue: an unnecessary choice between data accuracy and burden reduction.

CMS estimates that increasing the number of POLs required to report data would not materially alter the ultimate payment methodology because the volume distribution is so heavily skewed in favor of independent laboratories but would “likely impose significant administrative burdens on physician offices” [83 FR 35861]. We concur, and therefore do not consider increasing the low expenditure threshold to be a viable policy solution and would not support any proposal to this effect.

To the extent that CMS adjusts the applicable laboratory definition, MGMA strongly urges CMS to avoid implementing revisions that would result in increased burden on POLs. Mandating POLs to report enormous sums of pricing data is not a good use of time as physician group practices are attempting to implement the Medicare Access and CHIP Reauthorization Act (MACRA) and move toward joining APMs. The data reporting process causes massive disruption to clinical workflow and undermines other serious efforts toward quality improvement. Moreover, requiring such a significant reporting burden is at odds with the agency’s stated mission of reducing regulatory burden.

For future data collection periods, which must occur every three years, MGMA strongly urges CMS to make significant modifications to its approach to collecting private payer pricing information, beyond the revisions addressed in this proposed rule.

First, we strongly urge CMS to provide group practices with advanced notice if an in-office laboratory meets the regulatory definition of an applicable laboratory and therefore must collect and report data. This will enhance the accuracy and reliability of the data that CMS will rely upon to calculate future payment rates under the CLFS. Providing notice also mitigates the risk of group practices potentially receiving significant civil monetary penalties for inadvertently misclassifying the in-office laboratory and declining to submit data. At the very least, the agency must take steps to clarify the definition, through sub-regulatory guidance materials immediately following the publication of the final rule.

¹ Summary of Data Reporting for the Medicare Clinical Laboratory Fee Schedule (CLFS) Private Payor Rate-Based Payment System, Sept. 22, 2017, available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2018-CLFS-Payment-System-Summary-Data.pdf>.

² 81 Fed. Reg. 41036, 41094 (June 23, 2016).

CMS should also permit excluded laboratories to voluntarily report data. MGMA emphasizes this does not mean that all excluded POLs want to report, as implied in the proposed rule. Rather, laboratories should at least be given the opportunity to submit data to be included in CLFS rate calculations; for example, if the laboratory collected data but subsequently determined they did not qualify as an applicable laboratory. The statutory language does not prohibit voluntary reporting and allowing more laboratories to submit pricing data furthers CMS' goals of collecting as much applicable information as possible.

In addition to modifying the process for collecting and reporting data, CMS must take steps to address data integrity concerns and to ensure a valid stratified random data sample is collected by CMS that represents all segments of the laboratory market. CMS must also ensure a more transparent process for rate-setting and publish detailed information to the public such that stakeholders can assess the accuracy of data submissions.

The agency should engage in a constructive dialogue with the stakeholder community on ways to improve the PAMA data collection and reporting process and to discuss alternatives. For example, MGMA recommends CMS use another approach to CLFS recalibration, such as sampling a geographically diverse set of laboratories, including POLs; requesting contracted rates for the most common Medicare lab services; or surveying private payers about the rates paid to laboratories. CMS has used surveys in other systems, such as the global surgical code data collection undertaking. By requiring a sampling of laboratories representing each sector of the national market to report, such system would yield more accurate, market-based data, while limiting the reporting burden to laboratories that are part of the sample.

Burden reduction

CMS proposal (83 Fed. Reg. 35861): CMS requests feedback from POLs and small independent laboratories on the administrative burden of reporting to inform future policy on the low expenditure threshold.

MGMA comment: Although CMS estimated that only 5% of POLs would be responsible for reporting pricing data during the inaugural CLFS revaluation cycle, the number of POLs required to collect and analyze pricing data was much larger because group practices needed to determine whether they met required revenue thresholds. Unfortunately, CMS did not notify POLs whether they were responsible for reporting, which left many laboratories in doubt as to their status and faced with potentially massive civil monetary penalties if they chose incorrectly. Deciding this first step resulted in mass confusion, and CMS sub-regulatory guidance was unclear and at times inconsistent.

Particularly in a small practice, complying with a massive reporting undertaking subtracts from attention that would otherwise be paid to other reporting initiatives and priorities. Moreover, the inaugural reporting period in early 2017 not only overlapped with the meaningful use attestation deadline, it also coincided with the first reporting period under MIPS. One MGMA member informed us: "I spent so much time on it I accidentally missed the meaningful use submission date and even though we appealed, we were denied. Submitting the lab data cost us a huge amount of money."

Vendors were generally unprepared throughout the data reporting period. One leading EHR vendor informed an MGMA member they were unaware of PAMA lab reporting requirements as late as March 2017 (days before the original deadline for data submission). While some vendors offered reporting solutions, those functionalities came at a cost.

When asking for feedback from the laboratory community, CMS does not inquire or express concern about the impact of reduced reimbursement rates under the CY 2018 CLFS; however, a picture of the administrative burden of this rule is incomplete without considering how rate reductions have impacted laboratories to date. This impact is best illustrated by the following example. An MGMA member in a nephrology practice describes how laboratory results play a critical role in shared decision making among a nephrologist and a patient; patients arrive early to appointments to receive in-office lab work, which is then processed in-house. The physician reviews the results and then incorporates findings into the office visit, to discuss any changes needed to a patient's care plan, medication regimen, diet, or activity level. As a result of PAMA laboratory cuts, the nephrology practice has ceased offering certain testing because the reimbursement rate no longer supports the expense of the laboratory reagents to perform the test in-house. Medicare is the practice's largest payer, but private payers have begun adopting the Medicare rates, further exacerbating the impact of the cuts. The practice is concerned they will not be able to make necessary equipment upgrades once certain contracts expire, even though the group is already looking for savings opportunities with vendors to lower material costs. Adding on an additional expense at this point, such as to implement processes for a data collection or reporting period, is untenable for some small office laboratories.

While MGMA appreciates the opportunity to provide feedback on administrative burden associated with the low expenditure threshold, CMS' narrow focus on changes to the applicable laboratory definition will not result in the type of meaningful change that is needed.

Part B Drugs

Application of an Add-on Percentage for Certain Wholesale Acquisition Cost (WAC)-Based Payments

CMS proposal (83 Fed. Reg. 35854-35855): Consistent with recommendations by the Medicare Payment Advisory Commission (MedPAC), CMS proposes to reduce the add-on payment amount from 6% to 3% for Part B drugs utilizing Wholesale Acquisition Code (WAC).

MGMA comment: Medicare reimburses physicians and hospitals for the cost of Part B drugs at a rate tied to the average sales price (ASP) for all purchasers plus a percentage of the ASP. Currently the percentage add-on is 6%, which is then reduced to 4.3% under the budget sequester enacted in 2011. Discounts and rebates negotiated by very large purchasers but not typically available to physician practices are included in the calculations. Wholesale fees and state taxes that often are paid by many physicians also are not included. As a result, the ASP is often lower than the physician's price and even with the 4.3% add-on, Medicare reimbursement may not cover physicians' costs. Consequently, care for patients who require Part B drugs has been shifting out of physician offices and into hospital outpatient departments. Costs to Medicare and patients rise as a result because when drugs are delivered in an HOPD, there is a payment to the facility as well as a payment to the physician.

When a new drug comes to market and there is no data on discounts, rebates and actual prices, payments are based on WAC plus 6% (or 4.3% after the sequester cut). Data is collected during the first full quarter the drug is available and then incorporated into an ASP two quarters later. MedPAC argues that this means that Medicare reimbursement typically exceeds the ASP for the first nine months a drug is on the market. Based on a comparison of WAC to ASP prices for eight drugs, the Commission recommended that reimbursement for new drugs be reduced to WAC + 3% which becomes 1.4% after sequester and represents a drop of three percentage points before the sequester is applied and 4.6 percentage points after the sequester.

MGMA opposes this provision because as laid out above, the ASP's structure leads to prices that are inadequate for smaller purchasers such as physician offices, and any policies that use the ASP as the basis for other drug payment policy will only exacerbate the problem. Moreover, even if driving payments for new drugs down to the ASP level were an appropriate policy, we do not believe that the data MedPAC analyzed justifies a change of this magnitude. Specifically, of the eight drugs in the analysis, only two (where the ASP reimbursement rate was 2.7% lower than the WAC rate) showed price differences that came close to 3%. For the other six, ASP rates were 0% to 2.1% lower than WAC rates.

Enactment of the proposal thus would trigger reimbursement cuts for new drugs that will preclude their use in most physician offices and hinder Medicare patients' access to new and innovative therapies that are more effective and/or less debilitating than existing drugs. MGMA strongly urges CMS not to finalize this proposal.

Appropriate Use Criteria (AUC)

The requirements for capturing and reporting the AUC data will impose a significant administrative burden and cost on both the ordering and furnishing professionals. The outcome of this onerous reporting process will identify only 5% or less of outlier ordering professionals. We believe that the intent of the Protecting Access to Medicare Act (PAMA), passed prior to the enactment of MACRA, can be achieved through alternative approaches outlined below.

Elimination of the Unique Consultation Identifier (UCI)

CMS proposal (83 Fed. Reg. 35869): "Since we did not finalize a proposal in the CY 2018 PFS final rule, we propose in this rule to use established coding methods, to include G-codes and modifiers, to report the required AUC information on Medicare claims. This will allow the program to be implemented by January 1, 2020. We will consider future opportunities to use a UCI and look forward to continued engagement with and feedback from stakeholders."

MGMA comment: MGMA agrees with the decision not to move ahead with a UCI for use in the AUC program, and cautions against its consideration in future years. CMS explored the potential of having each qualified Clinical Decision Support Mechanism (CDSM) return a UCI with each query that is performed by an ordering professional. The UCI would transmit to the furnishing professional, who would include it on the claim form. However, CDSM developers were not provided a standardized format for this identifier and, therefore, each CDSM has likely established different formats for the identifiers.

If CMS requires a UCI for reporting AUC data in the claim, standard codes must be established to provide the answer to the query – adheres, does not adhere, and not applicable – and added to the UCI. Also, CMS would need a key for the format of each CDSM's identifier to interpret which CDSM and which AUC within the CDSM were queried.

Further, the CDSM identifier would require a length sufficient to accommodate generating unique identifiers for an extended period. While shorter identifiers would be less prone to input errors, longer identifiers have a significantly higher risk of error when being manually entered into the practice management or billing systems. For these reasons, we recommend CMS not move ahead with requiring use of a UCI in any AUC program.

HCPCS G-code Proposal

CMS proposal (83 Fed. Reg. 35865): “Since we did not finalize a proposal in the CY 2018 PFS final rule, we propose in this rule to use established coding methods, to include G-codes and modifiers, to report the required AUC information on Medicare claims.”

MGMA comment: MGMA has several concerns regarding the implementation of the AUC program as proposed:

- HCPCS G-codes would not be assigned to new CDSMs in real-time as they are qualified by CMS. It is highly likely that there will be significant delays in the assignment by CMS of HCPCS G-codes and delays in code assignment could impact newly qualified CDSMs.
- The creation and reporting of new HCPCS G-codes and modifiers will be excessively burdensome to providers and their billing processes. MGMA members indicated that they will have to dedicate significant staff time and potentially add full-time staff positions to translate this new information into the appropriate codes and report them in the claims. Reporting HCPCS G-codes and modifiers would potentially require upgrades, testing, and template changes to practice management system and billing system software.
- Often during claims processing, the service lines are reordered by billing systems or clearinghouses, based on claims adjudication rules. The reordering of service lines could result in the procedure service line and AUC service line being separated. For a claim with multiple procedures and multiple related HCPCS G-codes, determining which service lines were tied together during data analysis would be difficult. While this is a real concern, solutions could be identified to tie the procedure and HCPCS G-code service lines to each other.

Reporting AUC Data on the Professional Claim

CMS proposal (83 Fed. Reg. 35865): “CMS had originally considered assigning a G-code for every qualified CDSM with a code descriptor containing the name of the qualified CDSM. The challenge to this approach arises when there is more than one advanced imaging service on a single claim. CMS could attribute a single G-code to all of the applicable imaging services for the patient’s clinical condition on the claim, which might be appropriate if each AUC consultation for each service was through the same CDSM. If a different CDSM was used for each service (for example, when services on a single claim were ordered by more than one ordering professional and each ordering professional used a different CDSM) then multiple G-codes could be needed on the claim. Each G-code would appear on the claim individually as its own line item. As a potential solution, we considered the use of modifiers, which are appealing because they would appear on the same line as the CPT code that identifies the specific billed service. Therefore, information entered onto a claim would arrive into the claims processing system paired with the relevant AUC consultation information.”

MGMA comment: In a situation where multiple advanced imaging services are provided on the same date, the ability to link the AUC code to the related service is critical. Reporting the identifier at the claim level means that the information in the identifier applies to all the service lines reported in the claim. Reporting the identifier at the service line means that the information can be directly related to the applicable service. The ordering professional will be evaluated based on the appropriateness of each service provided to patients and, therefore, the AUC code must be reported for each service. Any solution that calls for a claim level identifier to be applied to all service lines risks the accuracy of the information.

If a single AUC code is reported at the claim level and applied to multiple services that require AUC consultation, inaccuracies will occur in the data. If, for example, a rule is applied that if one service does not adhere, then all services are deemed to not adhere means that an ordering professional meeting 66% of the requirement is dropped to 0%. This approach would unfairly penalize ordering professionals who are being held accountable for their ordering practices.

A common approach to handling claim exceptions at the service line level is to “split the claim” and submit separate claims for the services that require special reporting. While solving the issue of reporting multiple CDSM queries, splitting the professional claim increases the administrative burden on the practice. Furthermore, this is not an option for facility claims. Current regulations require that outpatient services provided on the same date must be reported in one claim. (Note, as well, that the AUC program requires the national provider identifier (NPI) of the ordering professional be reported on the professional and institutional claims. While there is a segment in the 837P to report the ordering provider’s NPI at the service line, the 837I does not have a place to report this information, either at the claim or service line.)

Should the program move forward, CMS must carefully consider the various solutions, including different reporting requirements for the professional and institutional claims, to report the AUC data before selecting a solution. It is critical that this solution be the least administratively burdensome and costly for the ordering and furnishing professionals and provides the necessary details to analyze accurately the behavior of ordering professionals.

Reporting on the Institutional Claim

CMS proposal (83 Fed. Reg. 35867): “Section 1834(q)(1)(D) of the Act specifies that the AUC consultation and reporting requirements apply only in an applicable setting, which means a physician’s office, a hospital outpatient department (including an emergency department), an ambulatory surgical center, and any other provider-led outpatient setting determined appropriate by the Secretary.”

MGMA comment: The AUC program requires the NPI of the ordering professional be reported in the professional and institutional claims (for outpatient services). While there is a segment in the professional claim to report the ordering provider’s NPI, the institutional claim lacks this segment. Changes to the institutional claim will need to be made to accommodate the reporting of the ordering professional’s NPI. Necessary changes and the timing of those changes are uncertain at this time.

The legislative interpretation is that the AUC data is required to be included in any claim being paid under an applicable payment system. CMS Transmittal 2040/Change Request 10481 establishes a HCPCS modifier of QQ (Ordering Professional Consulted a Qualified Clinical Decision Support Mechanism for this Service and the Related Data was Provided to the Furnishing Professional) for voluntary reporting from July 1, 2018 through December 31, 2019. CMS should allow the use of the QQ modifier in the institutional claim to meet the AUC data reporting requirement on a permanent basis. The QQ modifier will indicate that an AUC imaging study was performed and the related detailed AUC data have been reported in the professional claim. Presumably, CMS then can pair these claims when it analyzes the data to identify outliers.

Voluntary Reporting Period

CMS proposal (83 Fed. Reg. 35866): “On January 1, 2020, the program will begin with an educational and operations testing period and during this time we will continue to pay claims whether or not they correctly include AUC consultation information. Ordering professionals must consult

specified applicable AUC through qualified CDSMs for applicable imaging services furnished in an applicable setting, paid for under an applicable payment system and ordered on or after January 1, 2020; and furnishing professionals must report the AUC consultation information on the Medicare claim for these services ordered on or after January 1, 2020.”

MGMA comment: The CY 2018 PFS final rule established a voluntary reporting period from July 2018 through December 2019. The HCPCS QQ modifier was created to indicate that the ordering professional consulted the CDSM for the service, and the related information was provided to the furnishing professional. Due to the complexity of the AUC program and the lack of an established method for reporting the AUC data in the claim, we do not believe the program can move forward on January 1, 2020.

We recommend a different approach and urge the agency to make the AUC program voluntary and continue offering credit through the Improvement Activities component of MIPS. This will permit CMS to gather data on the types of diagnostic imaging services that have been identified by CDSM software as not appropriate. Once sufficient data has been gathered, CMS can work with the appropriate medical professional associations to educate ordering professionals regarding the ordering of appropriate advanced diagnostic imaging services. This achieves the goal set out in PAMA of reducing the volume of inappropriate services and not burdening physician practices.

Should the program move forward as proposed, the technical and workflow components involved in this AUC program will require systems and operation changes for providers, Medicare Administrator Contractors, and other involved payers. While CMS has delineated the first year of the AUC data reporting as a testing period, we do not believe this period should be used to work out the logistical details of the program. Comprehensive industry testing should not take place until after the program logistics have been determined and provider outreach and education completed. This designated testing period, established once the program logistics have been determined, will be critical for all organizations involved to implement the reporting requirements, verify system changes are functioning properly, and implement necessary workflow changes.

AUC Start Date

CMS proposal (83 Fed. Reg. 35865): “In the CY 2018 PFS final rule (82 FR 53190), we established the start date of January 1, 2020 for the Medicare AUC program for advanced diagnostic imaging services. It is for services ordered on and after this date that ordering professionals must consult specified applicable AUC using a qualified CDSM when ordering applicable imaging services and furnishing professionals must report AUC consultation information on the Medicare claim.”

MGMA comment: MGMA is very concerned about the AUC program’s administrative burden, cost, and impact to Medicare beneficiary access to care. Physician practices will be forced to incur the initial costs to implement the CDSM tool, whether incorporated directly into their EHR or as a standalone web-based program. Additional costs will be associated with the administrative burden (and clinician and practice staff time) to complete the CDSM query, transmit the AUC data with the clinical order, resolve any issues with the data at the time of the furnishing, and report the AUC data in the claim by the furnishing clinician. The time spent on this administratively burdensome program is time not spent delivering patient care.

We recommend CMS not implement the requirement for ordering professional to consult CDSM and for furnishing professional to report an AUC code on claims on Jan. 1, 2020, but instead establish the AUC program as a strictly a voluntary program.

Permitting Additional Personnel to Perform the AUC Consultation

CMS proposal (83 Fed. Reg. 35868): “We propose to revise the AUC consultation requirement specified at §414.94(j) to specify that the AUC consultation may be performed by auxiliary personnel under the direction of the ordering professional and incident to the ordering professional’s services.”

MGMA comment: We agree with the decision of the agency to expand the list of practice staff who will be permitted to perform the AUC consultation. This is recognition that, under the supervision of a physician, other clinical professionals in the practice can perform these duties. However, as we reference later in these comments, we maintain that a significant number of physicians themselves will be performing AUC consultations.

Hardship exceptions

CMS proposal (83 Fed. Reg. 35869): “We are proposing to revise §414.94(i)(3) of our regulations to adjust the significant hardship exception requirements under the AUC program. We are proposing criteria specific to the AUC program and independent of other programs. An ordering professional experiencing any of the following when ordering an advanced diagnostic imaging service would not be required to consult AUC using a qualified CDSM, and the claim for the applicable imaging service would not be required to include AUC consultation information. The proposed criteria include:

- Insufficient internet access;
- EHR or CDSM vendor issues; or
- Extreme and uncontrollable circumstances.”

MGMA comment: The ability of ordering providers to report a “real-time” AUC hardship exception at the time of the patient encounter will be a critical component of the program, should it move forward. The current proposal – to exempt AUC consultation requirements for ordering professionals experiencing insufficient internet access, EHR or CDSM vendor issues, and extreme and uncontrollable circumstances – needs to be defined further and expanded. For example, “insufficient internet access” cannot be defined as it is in this proposed rule (“Insufficient internet access is specific to the location where an advanced diagnostic imaging service is ordered by the ordering professional”) or in the way it has for other CMS reporting programs such as the Meaningful Use EHR Incentive Program. There, insufficient internet access was [defined](#) as follows:

“Eligible professionals who conduct 50 percent or more of their patient encounters in a county in which 50 percent or more of its housing units do not have availability to 3Mbps broadband (according to the latest information available from the FCC) on the first day of the EHR reporting period may exclude these measures.”

Ordering professionals most often will be drafting the advanced diagnostic imaging order during the patient encounter and, as such, will need access to the CDSM within their workflow. However, there could be situations where the organization’s internet is slowed significantly or is down temporarily, thus preventing the ordering professional from effectively consulting the CDSM during the patient encounter. These situations, while not meeting the current definition, would pose a clear hardship for the ordering professional. We urge CMS to broaden the definition of “insufficient internet access” to account for situations that are out of the control of the ordering professional. A delay in accessing the AUC data will not only result in additional time being wasted by the ordering professional and/or their staff but could result in the Medicare beneficiary being unable to receive an order during the encounter and forced to return to the practice.

Similarly, we urge CMS to expand the “extreme and uncontrollable circumstances” hardship exception for purposes of the AUC program. It should be broadened to include no physical access to the CDSM by the ordering professional, lost CDSM usernames or passwords, and other reasonable situations that prevent the ordering professional from consulting the CDSM at the time of the patient encounter.

We also recommend the addition of an exemption from the AUC program that mirrors the MIPS program’s low volume threshold. Ordering professionals that generate less than \$90,000 in Medicare charges *or* 200 patients *or* 200 covered services should be exempt from the AUC program. These “low volume” ordering professionals should not be required to purchase and utilize CDSM software.

Reporting an exception, however, will require additional work for the practice within the workflow of reporting AUC data. The furnishing professional will need to be aware that an exception is applicable to the service performed. Clear instructions will need to be provided for identifying a hardship exception and what is reported in the claim when an exception is present.

Impact Analysis

CMS proposal (83 Fed. Reg. 36049): “Specifically, we include a proposal regarding who, when not personally performed by the ordering professional, may consult AUC through a qualified CDSM and still meet the requirements of our regulations. In the CY 2018 PFS final rule, we estimated the consulting requirement based on the 2 minute effort of a family and general practitioner to result in an annual burden of 1,425,000 hours (43,181,818 consultations (Part B analytics 2014 claims data) × 0.033 hr/consultation) at a cost of \$275,139,000 (82 FR 53349) ... Due to this proposed change, we estimate that the majority, or as many as 90 percent, of practices would employ the use of auxiliary personnel, working under the direction of the ordering professional, to interact with the CDSM for AUC consultation for advanced diagnostic imaging orders.”

MGMA comment: CMS has estimated that, on average, an AUC consultation by an ordering professional will take 2 minutes. We disagree with the calculation of “the 2-minute effort” to consult AUC through a qualified CDSM as there are numerous situations that would require additional time:

- Not all clinical situations will require the ordering professional to consult a CDSM and report the AUC adherence. CMS has published the first list of priority clinical areas that will require CDSM consultation. This list must be reviewed by the ordering professional to determine if the clinical area requires CDSM consultation, which is complicated when a patient has multiple conditions that require advanced diagnostic imaging services but do not require CDSM consultation or reporting to the furnishing professional.
- For those ordering physicians who do not have CDSM incorporated into an EHR, they must go outside their automated clinical workflow and log in to a separate website. This will require the ordering professional to look up the username and password, wait for webpages to load, conduct the AUC consultation, and record the results.
- More complex clinical situations will require ordering clinicians to use various search terms to more accurately reflect the patient’s condition.
- Patients may present with conditions that require the ordering professional to consult more than one CDSM.
- Invariably, there will be communication issues between ordering and furnishing professionals. For example, when a furnishing professional receives an order for a patient who they believe could require an AUC adherence code but does not contain one, they will be forced to contact the ordering professional’s office to either find out why the code was not included or have the ordering professional send a code, thus adding additional administrative burden to the process.

We also disagree with the assumption made in the proposed rule that 90% of AUC consultations will be made by auxiliary personnel. We anticipate that a significantly higher percentage of AUC consultations will be performed by a physician than estimated by CMS. Practices that have incorporated CDSM software into their EHR are more likely to have the ordering physician conduct the AUC consultation as it will still be within the physician workflow during the patient encounter. Auxiliary staff will be more likely to consult the CDSM when it is required to leave the workflow and log in to a separate AUC consultation website.

We also expect that in most clinical cases, the appropriate diagnostic imaging service will be long-established, and the CDSM consult will simply confirm the physician's initial selection. For a small number of clinical situations, however, where the appropriate diagnostic imaging service is not intuitive, it is likely that the physician will consult the CDSM to ensure that the patient's condition is correctly imputed and review the recommended imaging service.

The following illustrates the impact the AUC program will have on practice operations and patient access to care, including Medicare beneficiaries:

Time Estimations (CMS CY 2019 PFS Proposed Rule)

- Annual burden, based on the CMS-estimated 2-minute AUC consultation: 1,425,000 hours (85,500,000 minutes) with 90% attributed to auxiliary staff, 10% to physicians
 - Based on an average primary care visit of [16.6](#) minutes, the AUC requirement will result in a loss of **515,060** physician-patient visits per year and, using the CMS estimate of 1,282,500 hours used by registered nurses to consult with a qualified CDSM, a loss of **160,313** nursing days per year

Even if we are to accept the CMS estimation of 2 minutes per AUC consultation and 90% of AUC consultations conducted by auxiliary staff, the cumulative effect of the requirement will be a significant burden to physicians and their staff and result in a significant loss of patient visits and nursing days.

Training and Education

MGMA comment: We urge CMS to offer comprehensive training prior to any requirement for professionals to consult AUC and report that consultation on a claim. As well, some EHRs will have the CDSM integrated into it and this type of integrated system will alert the ordering professional when the AUC requirement is applicable to the service being order. However, for ordering professionals who have to query a separate CDSM tool, they will need to know when to use the CDSM. Providing a list of the specific procedure codes for which the AUC query is applicable will ease the burden of the ordering professional determining when the query is required.

Should the furnishing professional have an integrated EHR and billing system with the ordering professional, the AUC data would likely be captured in the EHR and can then be transmitted to the billing system for reporting in the claim. However, for the majority of providers that do not have this type of integrated system, the furnishing professional will need to manually enter the AUC data into the billing system or into the claim. CMS should keep the AUC data reporting requirements as simple as possible to avoid mistakes during manual entry that could cause the claim to pend or reject.

Solutions

CMS proposal (83 Fed. Reg. 36055): "Data derived from the CCW 2014 Part B non-institutional claim line file, which includes services covered by the Part B benefit that were furnished during CY

2014, identified approximately \$3,300,000,000 in total payments for advanced diagnostic imaging services. If implementation of this program led to a 30 percent decrease in total payments, then we would expect \$990,000,000 in fewer payments annually.”

“Indeed, the Institute for Clinical Systems Improvement in Bloomington, Minnesota, performed a clinical decision support pilot project to (1) improve the utility of diagnostic radiology tests ordered, (2) reduce radiation exposure, (3) increase efficiency, (4) aid in shared decision making, and (5) save Minnesota \$84,000,000 in 3 years (Miliard, 2010). It is hypothesized that these benefits are the result of educating ordering professionals on the appropriate test for a set of clinical symptoms, rather than just adding time and electronic obstacles between ordering physicians and advanced diagnostic imaging services (Sistrom et al., 2009) as such transfer of knowledge can alter clinical practice” (emphasis added).

MGMA comment: CMS has set an extremely ambitious goal of reducing total payments for advanced diagnostic imaging services by 30 percent. We all can agree that unnecessary advanced diagnostic imaging services for Medicare patients wastes limited resources, costs tax payers, and can be harmful to patients in the form of unnecessary radiation exposure. However, imposing onerous administrative requirements on all ordering and furnishing professionals with the goal of identifying a small group of outliers will not solve the problem.

The citation above from the proposed rule is critical to help identify an appropriate solution to inappropriate advanced diagnostic imaging services. As the passage in the rule suggests, physician education will be the driving force to limit inappropriate ordering, not “just adding time and electronic obstacles between ordering physicians and advanced diagnostic imaging services.”

PAMA requires CMS to collect two full years of data prior to imposing any prior authorization requirement of ordering professionals. Even assuming the timeline laid out in this proposed rule is adhered to, the outlier ordering professionals would not be required to conduct a prior authorization transaction until 2023 at the earliest. We recommend the following actions to achieve the same goal of the AUC program but faster and with a considerably reduced administrative impact on physicians, their staff, and Medicare beneficiaries.

CMS should:

- Use the principles and intent of MACRA to guide cost reduction and value-based activities;
- Increase the multi-category MIPS weight for consultation of CDSM software in the Improvement Activities, Quality, Cost, and Promoting Interoperability components of MIPS;
- Sponsor AUC conferences, webinars, and other forms of professional education (i.e., offering CEUs for physicians) to discuss the clinical and economic value of CDSM consultation;
- Offer several CDSM options free of charge to ordering professionals; and
- Work with the appropriate medical specialty societies and professional associations such as MGMA, with emphasis on primary care physicians, to focus on disseminating educational opportunities, distribution of evidence-based research, and distribution of free CDSM tools.

Merit-based Incentive Payment System (MIPS)

MIPS reporting period

CMS proposal (83 Fed. Reg. 35893): CMS previously established a full calendar year reporting period for the quality and cost performance categories, while the promoting interoperability and improvement activities categories continue to be any 90 days. Eligible clinicians (ECs) and groups who

report less than 12 months of data would be required to report all performance data available from the applicable performance period.

MGMA comment: MGMA strongly opposes a full calendar-year reporting period for the quality performance category of MIPS and urges CMS to establish a minimum 90-day reporting period for all MIPS categories that require data collection and reporting by group practices and ECs, including quality and promoting interoperability.

The agency recognizes the significant benefits of a minimum 90-day reporting period in this rule, which provides: “a 90-day performance period is necessary in order to enable clinicians to have a greater focus on the objectives and measures that promote patient safety, support clinical effectiveness and drive toward advanced use of health IT” (83 Fed. Reg. 35893). CMS also outlines challenges associated with reporting data across a full calendar year due to “clinicians newly employed by a health system or practice during the course of a program year, switching CEHRT, vendor issues, system downtime, cyber-attacks, difficulty getting data from old places of employment, and office relocation” (83 Fed. Reg. 35893).

MGMA agrees these concerns are valid. The enumerated challenges create obstacles outside the control of the group practice, which inhibit their ability to collect and report 12 months of MIPS data to CMS – not just for the promoting interoperability and improvement activities categories but also for the quality performance category of MIPS.

Physician practices must take many steps prior to the start of the performance period to ensure that the proper systems are in place and the necessary data is being accurately collected throughout the performance year so that it can be properly submitted during the subsequent attestation period. For example, clinicians and practices must study amended measure specifications and select the requisite number of clinically-relevant measures, train their staff, and often input the measure information as discreet data into the EHR. Otherwise, a third-party data submission vendor or registry cannot extract the necessary data, nor submit it to CMS, such that a full calendar-year of data is provided. Starting at the outset of the performance period is even more critical for clinicians who report via Part B claims, because quality code information must be included when the claim is processed for payment. Requiring ECs and group practices to accomplish this heavy lift between early Nov. when the final policies and measures are released, and Jan. 1 is unrealistic.

Moreover, if CMS truly intends to influence clinicians and practices to improve care by evaluating quality, cost, EHR use, and practice improvement metrics, desired evidence-based actions must be taken at the point of care, starting on the first day of the performance period. For instance, an MGMA member practice reported CMS quality measure #376, one of the electronic clinical quality measures. In 2017, the measure specifications evaluated functionality assessments prior to hip surgery and 60-180 days after surgery. In 2018, the measure specifications changed to evaluate whether a functionality assessment was performed prior to hip surgery and 270-365 days after the procedure. Because the eligible procedures must have occurred during the year prior to the performance period, this member’s group practice had already performed many of the second functionality assessments according to the previous specifications when they were made aware of the measure changes in mid-year 2018. They were then left with the option to conduct a third functionality assessment merely to meet the measure, report data that did not truly reflect their quality of care as it would show them out of compliance more often than not, or choose to report a different measure entirely more than halfway through the performance period. Scenarios like this one are not uncommon and reinforce the difficulty of complying with ever-changing measure protocols without a shorter reporting period.

We acknowledge that certain reporting options, such as reporting certain outcome-based measures, may require a lengthier reporting period than 90 days to ensure statistical validity, and we encourage CMS to permit groups to report data for longer periods of time in such circumstances. However, we strongly encourage CMS to look for opportunities to shorten the minimum statistically-valid reporting period across all data submission methods. When reporting all-payer data via QCDR, registry, or EHR, any 90 consecutive days should provide a sufficiently reliable data set. Moreover, CMS' case minimums for the cost measures are much lower, at 10, 20, or 35 cases. If those case minimums are valid for cost measures, CMS should consider applying the same logic to quality case minimums.

Moving to a shorter reporting period would also allow for a number of program improvements. A 90-day reporting floor would reduce the administrative burden in MIPS, align the reporting period across MIPS categories, allow the agency to shrink the problematic two-year lag between performance and payment, and increase the timeliness and relevance of feedback, which could be provided on a quarterly basis, as recommended by Congress. Establishing a 90-day reporting floor would also give CMS an opportunity to set benchmarks based on more current data, rather than from four years prior to the payment year.

Furthermore, we urge CMS to consider the timing of MIPS feedback reports, which are released halfway through the 365-day reporting period, limiting the effect of any improvements made as a result of feedback to, at best, only one-half of the performance period. For instance, physician practices may need to conduct internal due diligence to identify quality performance variables, explore more clinically relevant reporting metrics and change data capture and input into the EHR, which would require action by third-party vendors who are not subject to the same payment penalties as physicians. If the reporting period were reduced to a 90-day minimum with the option to submit additional data, physicians and group practices would have greater flexibility to incorporate the MIPS feedback into their performance and focus more of their attention on improving patient care as opposed to reporting for reporting's sake.

Low-volume threshold

CMS proposal (83 Fed. Reg. 35886): CMS proposes to maintain the low-volume threshold, which excludes ECs and groups that bill \$90,000 or less in Medicare Part B charges or see 200 or fewer Medicare beneficiaries. As required by the Bipartisan Budget Act of 2018, the agency would add a third criterion for the low-volume threshold, which would also exempt from MIPS ECs and groups who provide 200 or fewer covered professional services to Part B-enrolled individuals.

MGMA comment: In MACRA, Congress recognized small practices often lack the infrastructure and resources to comply with complex reporting programs, particularly when Medicare patients make up a small portion of their patient mix, and established the low-volume threshold to mitigate adverse effects on small and rural practices. MGMA supports CMS' proposed low-volume threshold to reduce the burden on small practices and practices with a low Medicare patient population and mitigate the confounding variables solo practitioners and small groups face comparative to large, resource-rich group practices. The Association also believes the third low-volume threshold criterion, as required by the Bipartisan Budget Act of 2018, is appropriate until significant reforms to simplify MIPS can be implemented.

CMS should ensure ECs and groups understand where they fall in relation to the low-volume threshold in advance of the performance year. MGMA heard from dozens of group practices in the beginning of 2018 who were wondering whether they would be required to participate in MIPS based on their Medicare patient and reimbursement volume. To avoid confusion and frustration, CMS should clearly

and accurately communicate MIPS eligibility information to clinicians and groups at the outset of the performance period.

Low-volume threshold opt-in

CMS proposal (83 Fed. Reg. 35887): CMS would allow ECs and groups who fall below the low-volume threshold according to one or two – but not all three – criterion to opt-in to report MIPS data and receive a corresponding payment adjustment. Those ECs and groups who wish to opt-in would need to affirmatively make an election via the qpp.cms.gov website.

MGMA comment: MGMA appreciates CMS' flexibility in allowing interested ECs and group practices who would otherwise be excluded from MIPS under the low-volume threshold to opt-in through an affirmative election. We believe this is preferable to using MIPS data submission as a signal that an EC or group wants to opt in, as those clinicians and groups may not realize the consequence of voluntarily reporting while eligible to opt-in, particularly if they have been reporting quality measures on a voluntary basis in the past. When the agency releases MIPS eligibility data, we urge CMS to also make plain whether an EC and group practice is eligible to opt-in to MIPS, what this decision could mean in terms of reducing or increasing their Medicare payments, and that the decision will be final.

Furthermore, CMS should provide eligibility information prior to the start of the performance period, so ECs and groups who want to opt-in to MIPS have the information necessary to make an informed choice about their participation options. Additionally, we urge the agency to allow an opt-in decision at any point during the data submission window and to provide confirmation of the decision to opt-in. We continue to hear from MGMA members throughout the country that confirmation of MIPS data submission and attestation is expected both for purposes of internal compliance records and in preparation of potential downstream audits. We urge the agency to provide confirmation of an EC's or group's decision to opt-in.

Part B services subject to MIPS payment adjustment

CMS proposal (83 Fed. Reg. 35890): As required by the Bipartisan Budget Act of 2018, CMS proposes to apply the MIPS adjustment factor and additional MIPS adjustment factor for exceptional performance to Part B payments for covered professional services beginning in 2019.

MGMA comment: MGMA supports the technical amendment made by Congress in the Bipartisan Budget Act of 2018 to clarify that items or services beyond the physician fee schedule, especially Part B drugs, should not be included when determining MIPS eligibility and applying the MIPS payment adjustment. These are essentially pass-through payments for the cost of acquiring these drugs, and so applying either bonus or penalty adjustments to them would be inappropriate. Including these additional items and services is a significant departure from previous policy. Although in the past CMS has counted Part B drugs in the calculation and comparison of physician costs under the Value-Based Modifier (VBM), none of the MIPS legacy programs, including Meaningful Use (MU), Physician Quality Reporting System (PQRS), and VBM applied related adjustments to reimbursement for the drugs. MACRA was intended to build-off of these previous programs. Yet, nowhere in the legislative history is there notice or discussion of making a significant change to include additional items and services. We therefore believe Congress intended, and CMS should carry over, a similar policy in MIPS.

Sub-group reporting option

CMS policy (83 Fed. Reg. 35891): CMS is seeking comments regarding establishing a sub-group reporting option and creating a new identifier for participation of groups other than as defined by the tax identification number (TIN).

MGMA comment: MGMA is opposed to carving up the group practice solely for purposes of MIPS reporting. Value-based improvements are largely designed and implemented at the group practice level. These include coordinating care, developing a robust health IT infrastructure, demonstrating clinical practice improvement, and identifying and reducing potentially wasteful resource use – all of which are necessary ingredients for success in MIPS. MGMA is concerned that partitioning group practices would undercut a practice’s ability to incentivize quality improvement behaviors among all its staff, including but not limited to clinicians, and collectively manage the impact of MIPS. We oppose any effort that sacrifices the efficiencies and advantages of the group practice model for the sake of collecting more MIPS data.

Although CMS does not elaborate on its rationale for exploring this option, it is presumably in response to stakeholder concerns that MIPS is not clinically relevant to specialists and providers who practice in various care settings. We share this concern. However, rather than dismantle the group practice, CMS pursue a more fundamental solution to enhance the clinical relevance of MIPS through program improvements. In addition to the recommendations above, we believe allowing group practices to report MIPS category data using multiple submission mechanisms will give groups greater flexibility to choose measures, particularly quality measures, that match their clinical objectives. We also support the hospital-based reporting option for clinicians who furnish most of their care in the facility setting. Finally, we urge CMS to work closely with measure developers and specialty societies to fill measurement gaps across all MIPS categories.

There are significant operational challenges with this proposal. Applying the MIPS payment adjustments at a sub-group level would create a chaotic scenario in which various factions within a group are subject to different Medicare payment rates, which would be problematic for groups who contract with Medicare Advantage and private payers at the group practice level and add further complication any time a provider switches practices. Moreover, sub-dividing the group raises a question about whether CMS would create a new, unique MIPS identifier. MGMA opposes moving away from use of a group’s TIN as its MIPS identifier. Basing payment and performance on the TIN reduces administrative burden on practices, equalizes payment adjustments across all clinicians in the TIN, and creates incentives for clinicians to move to higher-performing practices, creating an overall more competitive quality environment in healthcare.

For these reasons, MGMA urges CMS to continue supporting and encouraging the group practice model by defining a group practice at the TIN level and allowing practices to determine a MIPS approach that reflects their clinical quality improvement efforts through greater flexibility and reduced burden.

Collection types, submission types and submitter types

CMS proposal (83 Fed. Reg. 35893): CMS proposes new terminology to define the set of quality measures with comparable specifications and data completeness criteria as collection types, including eQMs, MIPS CQMs, QCDR measures, Medicare Part B claims measures, CMS Web Interface measures, the CAHPS for MIPS survey, and administrative claims measures. Similarly, CMS would introduce a new concept, the submitter type, to define the MIPS EC, group or third-party intermediary

acting on behalf of a MIPS EC or group that submits data on measures and activities under MIPS. CMS would also add a new definition for submission type, which would refer to the way an EC or group reports data to CMS, including “Direct, log in and upload, log in and attest, Medicare Part B claims and the CMS Web Interface.”

MGMA comment: MGMA encourages CMS to better promote clarity and stability in the MIPS program. Requiring practice administrators and clinicians to re-educate themselves year-over-year about substantive policy changes to the reporting requirements, coupled with seemingly arbitrary changes in terminology is unreasonable. We advise the agency to err on the side of stability when considering program terminology. If the agency does move forward with this proposal, we recommend “measure type” or “measure category” in lieu of “collection type” to more intuitively and accurately reflect the meaning of the term.

Regardless of the agency’s terminology re-branding decisions, the best way to improve the physician community’s understanding of the program requirements, measure specifications, and scoring rules remains the same: release information about the program prior to the start of the performance period. As in 2017, medical group practice leaders did not have basic eligibility information until the second quarter of 2018. Even more inexcusably, CMS published the following essential measure information after the program year had begun on Jan. 1, 2018:

- Quality Measure Specifications, published Feb. 9, 2018
- Qualified Clinical Data Registry (QCDR) Measure Specifications, published May 29, 2018
- Promoting Interoperability Measure Specifications, published June 6, 2018
- Cost Measures, published July 27, 2018
- Quality Measure Specifications supporting documents, published July 31, 2018
- Web Interface Measures & supporting documents, published Aug. 7, 2018
- MIPS data validation criteria, published Aug. 16, 2018

Lack of information not only disadvantages group practices in complying with MIPS but also hampers their ability to capture the information at the point of care, track the data, and make any necessary adjustments throughout the performance period. If CMS is serious about MIPS as a quality improvement program, the agency needs to release all measure and eligibility information prior to the start of the performance period.

MIPS quality performance category

Data submission criteria

CMS proposal (83 Fed. Reg. 35897, 36315): CMS does not propose to change its policy that ECs and group practices generally report data on six quality measures, including at least one outcome measure (or high-priority measure if no outcome measure is available), or one specialty measure set, for 60 percent of applicable patient encounters, including patients covered by private payers if reporting via registry, QCDR, or EHR. CMS would continue to measure the all-cause hospital readmission rate for groups with 16 or more ECs who meet the 200-case minimum. Meanwhile, as outlined in Table C of Appendix 1, CMS proposes to remove 34 quality measures.

MGMA comment: MGMA continues to advise the agency to reduce the reporting burden in this category by decreasing the data submission requirements and allowing ECs and group practices to report additional quality measures at their discretion. MGMA regularly hears from physician group practices that it is challenging to identify six clinically-relevant measures, even within the specialty measure sets. Rather than requiring practices to split their focus among measures that may not be as

relevant to their patient population and clinical specialty, reducing the reporting requirements would allow practices to prioritize their energy and resources on a few meaningful measures that, if performed well, could move the dial on improving care and reducing costs.

We have concerns about the feasibility of a 60% data tracking and reporting threshold, as it reduces any wiggle room a group practice may need to make technological infrastructure changes or address any system interruptions or other administrative factors that often fall outside the control of the physician or practice. Moreover, expanding most reporting mechanisms to all-payer data inherently increases the amount of data the agency receives, calling into question any need to increase the threshold.

We urge CMS to reexamine the utility of a 60% data completeness threshold and seek stakeholder feedback regarding any increase in the threshold only when program data show a large majority of group practices are meeting existing data completeness requirements. For cost measures, the agency requires only 10, 20, or 35 patient encounters to meet a reliability score of 0.4. For quality measures, MGMA submits CMS seriously consider an alternative data completeness threshold that meets a minimum reliability score of 0.80, which would increase the confidence that ECs and groups would have on their performance scores and comparisons. Moving to a minimum number of patients or some other predictable methodology also facilitates planning of resources and staffing required for this effort.

MGMA reiterates our ongoing opposition to CMS' use of the all-cause hospital readmission measure for group practices with 16 or more ECs who meet the case minimum. As the agency has done in the cost category, CMS should retire the flawed VPM population health measures. These measures were developed to evaluate outcomes at the community level with 100,000 patients and have very low statistical reliability at the individual clinician and group practice levels. Additionally, because these measures rely on the flawed VPM patient attribution methodology, they often hold practices and providers accountable for the outcomes of care they had very little influence over, particularly for specialty and rural practices. CMS must take this opportunity to address the myriad of problems identified in the previous programs, including the lack of clinically relevant measures for the vast majority of practices and specialties, and eliminate them from the quality performance category. Rather, CMS should make this measure optional in the improvement activities category, at least until these underlying problems can be studied and addressed.

Any refinements to this category must continue to allow ECs and groups flexibility to report across multiple mechanisms. There must also be an openness to accept and implement emerging measures that would demonstrate quality based on new evidence and data.

Medicare Part B claims reporting option

CMS proposal (83 Fed. Reg. 35894): CMS proposes to limit the claims-based reporting option to individual ECs in small practices and to make this option available to small practices who wish to be scored in MIPS at the group practice level – rather than as individual ECs.

MGMA comment: MGMA urges CMS to finalize the option to report claims-based measures and be scored at the group level – not just for small practices but for all MIPS-eligible group practices. Because quality measures are just one of four metrics group practices are evaluated on, we agree that groups should not be excluded from a collective evaluation merely because they report quality measures using the claims-based reporting mechanism. As we have stated in the past, many quality improvement initiatives, including enhancing health IT infrastructure and hiring new staff to coordinate

care, take place at the group practice level. Regardless of the method that a group uses to convey these quality improvement efforts to CMS, they should have the option to be evaluated for their joint value-based efforts to deliver high-quality patient care. Therefore, we urge CMS to allow group practices of all sizes to be evaluated in MIPS collectively as a group practice regardless of their choice of submission mechanism, including the claims-based reporting option.

As indicated above, MGMA opposes CMS' proposal to limit the claims-based reporting option to individuals and groups classified as small practices. The 2016 PQRS Experience Report, which is the most recent quality program feedback available, indicates claims-based reporting continues to be the most popular data submission mechanism. In fact, more than 310,000 clinicians reported PQRS quality measures using the claims-based reporting option. The claims-based reporting option is especially popular among hospital-based clinicians, including emergency physicians, nurse anesthetists, and radiologists, as well as primary care clinicians. If CMS' rationale is that the claims-based measures are topped out, it should move forward with its lifecycle for removing those topped out measures from the list with appropriate notice and work with measure developers to modernize the metrics and develop new measures. CMS should not limit the most popular data submission mechanism before ensuring there are clinically-valid alternatives for physicians.

Because CMS proposes to allow ECs and groups to submit the most clinically-relevant measures regardless of reporting mechanism for the first time in 2019, we strongly encourage the agency to retain the claims-based reporting option to give MIPS participants maximum flexibility to focus on the quality metrics that are the most meaningful to patient care, which may include claims-based measures. Finally, because CMS proposes to expand the definition of a MIPS EC, we are concerned that this proposal would coincide with a decrease in the number of group practices that will be considered small groups.

CMS Web Interface reporting option

CMS proposal (83 Fed. Reg. 35895, 35899): CMS would allow third-party intermediaries to submit data using the CMS Web Interface on behalf of groups. The agency seeks comment on expanding the CMS Web Interface submission type to groups consisting of 16 or more ECs. CMS also seeks comment regarding adding to the CMS Web Interface measure set to include other specialty specific measures, such as surgery.

MGMA comment: MGMA appreciates CMS' proposal to expand the availability of the CMS Web Interface reporting option to group practices with 16 or more ECs and to allow third-party intermediaries to submit data using the CMS Web Interface on behalf of groups. While we have concerns that group practices with 16-24 ECs, depending on their patient mix, may not meet the requisite sample size to report via this mechanism, we believe this reporting option should be available for those groups who do care for a significant number of Medicare Part B beneficiaries and who believe the CMS Web Interface measures are appropriate for their clinical priorities.

To assist these group practices in understanding whether they would have a sufficient Medicare patient volume to successfully report using the CMS Web Interface sampling method, CMS should provide them with data in advance of the registration deadline for this reporting option. One option would be to provide this data as part of the MIPS feedback report and to detail the patients that would have been attributed to the group had they selected the CMS Web Interface reporting mechanism.

We also support the agency's proposal to expand the cohort of measures available for reporting via CMS Web Interface. Expanding the availability of measures should also improve the probability that

practices with 16-24 ECs meet the patient attribution thresholds, as they may be able to select measures that are more applicable to their clinical focus.

“Topped out” measures

CMS proposal (85 FR 30045): CMS’ previously finalized policies to remove “topped out” measures after four years of high, unwavering performance and to cap “topped out” measures at six of ten points. In this proposed rule, CMS would remove “extremely topped out” measures through the rulemaking process after one year of identification as “extremely topped out.” Measures with an average mean performance within the 98th to 100th percentile would be deemed “extremely topped out.”

MGMA comment: MGMA has concerns about CMS’ proposal to deem certain measures as “extremely topped out” and remove them from the program after one year. First, we take issue with the belief that the quality reporting programs have reached the tipping point where physicians and group practices are selecting “topped out” measures that are easy to report. Instead, we hear regularly from members that they continue to see gaps in the current measure set and, as a result, struggle to select and report clinically relevant quality measures. Removing “extremely topped out” quality measures will only exacerbate this problem. Assuming the agency’s goal is to measure clinicians and groups on a core set of quality metrics, we believe retiring these measures in a single year would be premature and disruptive. Neither the health care industry nor CMS have reached consensus around a set of core quality measures. Further, the decile-based benchmark system already discourages physicians from reporting “topped out” measures. In many instances, performance on a “topped out” measure at any rate less than perfect – even 99.99% – earns just 7 or 8 points.

Rather than shortening the measure list based on “extremely topped out” status, CMS should take a more deliberate approach, ensuring the “topped out” measures proposed for removal do not disproportionately impact one reporting mechanism or specialty. We encourage CMS to defer to measure developers and national endorsement bodies regarding which measures are “topped out” as a result of being easy to report versus those that are “extremely topped out” because the desired outcome has become so commonplace as to warrant the retirement of the quality measure.

We request clarification regarding whether one measure may be deemed “extremely topped out” when reported via one submission mechanism, such as EHR, but not when reported via another submission mechanism, such as registry. If so, this would appear to be inconsistent with the intent of MACRA to allow ECs and group practices the flexibility to choose a reporting mechanism that is most clinically appropriate and most cost-effective for the group.

If CMS moves forward with its proposal, the agency must engage in a comprehensive education and outreach campaign to provide sufficient notice to physician group practices. In addition to labeling “extremely topped out” measures in all measure appearances, including on the QPP website and in the benchmark spreadsheet, CMS should notify physicians and groups in their feedback reports about whether any of the measures they submitted have been deemed “extremely topped out.” We urge CMS to work with data submission vendors to provide feedback to group practices that select “extremely topped out” measures and to provide feedback in the remittance advice to clinicians who submit data about a “extremely topped out” measure via claims.

Categorizing quality measures by value

CMS proposal (83 Fed. Reg. 35900): CMS believes that “not all measures are created equal” and “the value or information gained by reporting on certain process measures does not equate that which is

collected on outcomes measures.” Therefore, CMS is exploring a system where quality measures “are classified as a particular value (gold, silver or bronze) and points are awarded based on the value of the measure.”

MGMA comment: MGMA urges CMS not to move forward with an approach that would make the quality performance category of MIPS even more complex while many questions about this proposal remain unanswered. What if no “high-value” or “gold” measures are available only to certain specialists? What if “high-value” or “gold” measures are merely synonymous with highest-cost measures? It does not seem like a stretch to assume vendors would quickly figure out that they could charge more to collect and submit data regarding measures that are more valuable to physician practices in MIPS. What if “high-value” or “gold” measures exacerbate access to care problems for financially vulnerable or medically complex because they reward physician practices who seen relatively healthy, financially stable patients?

Furthermore, the agency is yet to release detailed, aggregate data about performance in the first year of MIPS. CMS continues to base its policy decisions on data from legacy programs, such as PQRS, which were retired by Congress in MACRA. CMS should wait to analyze those results and better understand which measures are being reported and how to recognize and better incentivize high-quality care without necessarily imposing more reporting requirements or costly mandates on physician practices.

Incentivizing reporting of CAHPS for MIPS survey

CMS proposal (83 Fed. Reg. 35948): To encourage groups to report the CAHPS for MIPS survey, CMS proposes to reduce the quality component denominator by 10 points in order to hold harmless any groups who were unable to be scored on the CAHPS for MIPS survey measures due to a low response rate or sample size. The agency seeks comment on opportunities to incentivize groups to submit the CAHPS for MIPS survey.

MGMA comment: MGMA agrees groups who invest in surveying their patients according to the CAHPS for MIPS survey should be held harmless from a reduction in their MIPS score if they are unable to be scored on survey measures due to a small sample size or low response rate, which is outside their control. To incentivize reporting the CAHPS for MIPS survey, CMS should first conduct an education and outreach campaign to group practices who would likely have a sufficient sample size to conduct the survey. Second, the agency should release the approved list of survey vendors prior to the deadline to register to report the survey data to CMS. In 2018, although the deadline to register to report CAHPS for MIPS survey measures was June 30, the agency did not release the list of approved vendors until Aug. 3. Finally, as the agency develops multi-category measure sets, it should consider the CAHPS for MIPS survey measure as a starting point for a measure set. In recent years, group practices have dedicated significant time and resources to engage patients in their care experience and should be recognized for these efforts by CMS through multi-category measure credit.

Scoring flexibility for measures with clinical guideline changes during the performance period

CMS proposal (83 Fed. Reg. 35949): CMS proposes to suppress a measure without rulemaking if, during the performance period, a measure is significantly impacted by clinical guidelines changes or other changes that CMS believes may pose patient safety concerns. The agency would publish suppressed measures “whenever technically feasible, but by no later than the beginning of the data submission period.” To hold harmless groups and ECs who are impacted by suppressed measures, “[s]coring for a suppressed measure would result in a [sic] zero achievement points for the measure and a reduction of the total available measure achievement points by 10 points.”

MGMA comment: While MGMA agrees that groups and ECs affected by suppressed measures should be held harmless, we have several questions about how CMS would verify that an EC or group practice intended to report the measure but changed course when the clinical guidelines changed. For instance, would there be an expectation that the group or EC would continue collecting and track data on a measure that could, as CMS states, pose patient safety risks? If not, would CMS hold groups harmless if they report less than 12 months' data for the suppressed measure as a result of clinical guideline changes?

To alleviate these and other issues, MGMA once again reiterates our position that CMS should permit groups and ECs to report a minimum of 90 days' data to the agency for full credit in MIPS. Related to this policy, if a measure is suppressed in July as a result of clinical guideline changes, a group or EC may continue to fully participate in the MIPS program by selecting another measure and choosing a 90-day window of data after July to submit to CMS.

Small practice bonus

CMS proposal (83 Fed. Reg. 35950): Rather than maintain its policy of adding five points to the final MIPS score of small practices, CMS proposes to add three points in the numerator of the quality performance category of MIPS for ECs in small practices if the MIPS EC submits data on at least one quality measure. CMS states its rationale for this policy as follows: "We want the final score to reflect performance, rather than the ability and infrastructure to support submitting quality performance category data."

MGMA comment: MGMA seeks clarification about this proposal. As drafted, it appears CMS would only add the three-point bonus to ECs who practice in small practices and who report as individuals. We would oppose any limitation of this bonus based on reporting at the individual EC level versus at the group practice level. We recommend CMS continue applying a bonus to small practices whether they report as individuals or groups.

Further, while we support the agency's efforts to level the playing field in MIPS and customize the program for small groups, we are worried this fix is merely a band-aid concealing foundational flaws in the MIPS program and masking an overly complex scoring methodology. Further, this band-aid has a short shelf life. The proposal is temporary and would be finalized, at best, two months before the start of the 2019 performance period. Physician group practices, especially those that struggle to find resources to devote to data collection and reporting, need certainty about how the program will affect their medical practice. Last-minute changes create confusion and drain limited practice resources.

Rather than tweak the program on an annual basis, we strongly encourage the agency to codify the small practice bonus for at least three years and to enact programmatic reforms to reduce the on all group practices so the agency can achieve its goal and the final MIPS score reflects performance, rather than the ability and infrastructure to support submitting quality performance category data. As outlined in more detail throughout this comment letter, we encourage the agency to reduce the performance period to any 90-day floor, gradually increase the performance threshold, and award cross-category credit for high-impact behavior.

Future approaches to scoring the quality performance category

CMS proposal (83 Fed. Reg. 35954): CMS believes "that removing the validation process to determine whether the eligible clinician has measures that are available and applicable would simplify the quality performance category significantly... A move to sets of measures in the quality

performance category, potentially with some criteria to define the clinicians for whom these measures are applicable, would eliminate the need for a validation process and for measures that are available and applicable. Moving to sets of measures would also enable us to develop more robust benchmarks. We also believe that in the next few years, we could remove the validation process for measures that are available and applicable if we set the denominator at a pre-determined level... and let clinicians determine the best method to achieve 50 points.”

MGMA comment: MGMA agrees the measure validation process is overly complex as designed and urges CMS to significantly enhance its capacity to inform groups and ECs of applicable quality measures prior to the performance period, regardless of whether they would otherwise be subject to the eligible measure applicability validation process. Significant time and resources are expended by medical practices on an annual basis to ensure they are collecting, tracking and reporting clinically applicable measures with the most up-to-date measure specifications. CMS could significantly lessen the burden of measure selection and validation by providing ECs and groups with more personalized information, based on their administrative claims data, about the most clinically relevant measures.

Regarding measures sets, MGMA would support re-introduction of this popular reporting option from the now-defunct PQRS into MIPS and allowing groups and ECs to report measures sets around a disease condition, procedure, specialty, or public health priority. We urge the agency to seek robust feedback from stakeholders and medical specialty societies to ensure the resulting measures groups are meaningful for clinicians and patients. Finally, to reduce provider burden, we urge the agency to collect the measures sets data on a statistically meaningful but minimally burdensome sample of Medicare Part B beneficiaries, such as the previous sample of 20 patients.

MIPS cost performance category

Cost category weight

CMS proposal (83 Fed. Reg. 35901-35902): CMS proposes to reweight the cost component of MIPS from 10% in 2018 to 15% in 2019.

MGMA comment: In the Bipartisan Budget Act of 2018, Congress extended the Secretary’s authority in MACRA to reweight the cost performance category to 10% for an additional three years. MGMA’s understanding of the intent behind this legislative amendment to MACRA is to give CMS more time to improve its approach to measuring resource utilization at the clinician and group practice level. Because the need to improve the cost performance category of MIPS outweighs the slight disadvantage of increasing the weight of the cost category in future years, MGMA urges CMS to maintain the cost category of MIPS at 10% in 2019.

CMS should spend the upcoming year addressing ongoing methodological barriers to measuring resource utilization. Namely, CMS needs to better identify and adjust for the cost of treating complex patients and must identify a more accurate way to apportion costs than holding a single physician responsible for the total annual cost of treating a particular patient. Recommendations for improving the cost component of MIPS include using more detailed specialty designations and recognizing sites of service and regional variations.

Further, CMS should not increase the weight of this category while the agency introduces episode-based cost measures for the first time. The agency should reserve time for any necessary program refinements, including opportunities to fairly assess performance for ECs and groups who are attributed episode-based cost measures compared to ECs and groups who are not. Further, it is critical

that the agency provide timely and actionable specifications regarding these measures. MGMA supports delaying an increase in the weight of the cost measurement category of MIPS until it is operationally feasible to provide cost and attribution feedback on at least a quarterly basis.

Cost measures

CMS proposal (83 Fed. Reg. 35902): CMS would continue to calculate the total per capita cost and Medicare Spending Per Beneficiary (MSPB) measures using administrative claims data. The agency also proposes to measure costs for eight episode-based cost measures, including five procedural measures and three acute inpatient medical condition measures.

MGMA comment: We continue to be extremely concerned that comparisons of EC and group performance using many of the current and future outcome and cost measures are likely to result in unfair and invalid assessments of the quality of care provided given the lack of or insufficient risk adjustment. This is further exacerbated when the erroneous assumption is made that it is appropriate to attribute administrative claims measures across all specialties. The problem is worsened by applying a low minimum reliability score (0.4) that means that accountability for costs will often be attributed inappropriately, particularly for ECs and groups that are just above the minimum case threshold.

If administrative claims-based measures continue to be used or are expanded, we strongly encourage CMS to explore whether the QPP portal could provide real-time information related to cost and quality measures derived from administrative claims data and potentially on improvement in the quality and cost categories. For example, it remains unclear to whom the cost category will apply in 2018 and may be even less predictable in 2019, creating essentially a “black box” around which participants might have the cost category applied to them and which individuals or groups may have reweighting occur. This concern also applies to other administrative claims measures used within the program such as the all-cause hospital readmission measure. We believe that CMS could develop estimates on the number of participants and types of practices that will or will not have the cost category measured based on historical data. Understanding the potential numbers and practice characteristics will assist in MGMA’s education and outreach efforts to our members, as well as assist practices with anticipating potential payment reductions and making the practice changes that are needed to avoid them.

Quantifying the costs of care is only one of the many activities and interventions that can be used to address and reduce unnecessary costs. We strongly believe that allowing physicians to receive credit for quality, promoting interoperability, or improvement activities in this category would reinforce the many avenues by which costs can be monitored and minimized as appropriate. For example, the use of clinical decision support (CDS) or appropriate use criteria (AUC) can ensure that evidence-based screenings and treatments are provided, while also preventing inappropriate costs.

Other cost drivers such as access to real-time data on referral sources would allow practices to problem-solve and implement effective interventions to prevent inappropriate utilizations such as emergency department visits or hospitalizations across the broader population and not just for each individual patient. For example, the work of the Transforming Clinical Practice Initiative may serve to fulfill the intent of this category, while also counting as an improvement activity and promoting interoperability measure. As access to this information increases, we believe that the cost category along with recognition of how quality measures, improvement efforts and health IT can collectively contribute to ensuring that patients receive evidence-based care will more effectively drive improvements and reduce unnecessary costs.

Cost measure reliability

CMS proposal (83 Fed. Reg. 35904): CMS proposes to retain a reliability threshold of 0.4.

MGMA comment: MGMA urges CMS to increase the reliability threshold. CMS has admitted 0.4 reliability is on the low end of the reliability spectrum but justifies low reliability as a tradeoff for higher variation among clinicians and groups. We see no reason why the application of low-validity measures to more ECs and groups outweighs concerns about reliability. In fact, we believe the agency should explain to physician practices and other stakeholders why it continues to include measures for which reliability is questionable and will very likely misrepresent physician practice performance.

MIPS Promoting Interoperability category

CMS proposal (83 Fed. Reg. 35913): “Accordingly, under §414.1375(a), the Promoting Interoperability performance category comprises 25 percent of a MIPS eligible clinician’s final score for the 2019 MIPS payment year and each MIPS payment year thereafter, unless we assign a different scoring weight.”

MGMA comment: MGMA believes ECs and groups submitting quality measures via end-to-end electronic reporting or using CEHRT in their Improvement Activities, should also earn full credit towards their Promoting Interoperability score. ECs use CEHRT and other tools that leverage interoperable standards for data capture, usage, and exchange to facilitate and enhance patient and family engagement, care coordination among diverse care team members, and to leverage advanced quality measurement and safety initiatives. CMS should recognize that if an EC or group is leveraging CEHRT to report quality measures or Improvement Activities, they are also demonstrating the use of technology to capture, document, and communicate patient care information and should therefore receive both quality and Promoting Interoperability credit.

With MACRA, Congress set out to streamline and harmonize the current siloed quality reporting programs. To satisfy congressional intent, CMS should award credit across multiple MIPS performance categories for certain high-impact behavior. Congress specifically directed CMS to award credit across the quality and Promoting Interoperability categories in Section 1848(q)(5)(B)(ii) of the statute:

“With respect to a performance period for a year, for which a MIPS EC reports applicable measures under the quality performance category through the use of certified EHR technology (CEHRT), treat the MIPS EC as satisfying the clinical quality measures reporting requirement under section 1848(o)(2)(A)(iii) of the Act for such year.”

MGMA recommends the agency reconfigure the MIPS scoring methodology and award Promoting Interoperability credit for reporting quality measures via end-to-end electronic reporting.

CMS proposal (83 Fed. Reg. 35913): “If a MIPS eligible clinician fails to report on a required measure or claim an exclusion for a required measure if applicable, the clinician would receive a total score of zero for the Promoting Interoperability performance category.”

MGMA comment: We are disappointed the agency has proposed to continue the “all or nothing” methodology for the MIPS Promoting Interoperability category as required in previous iterations of EHR reporting programs. Instead of rewarding ECs for using EHR technology to treat their patients,

the proposed rule outlines an approach that penalizes an EC for missing even one of the objectives by giving them zero points in the Promoting Interoperability category. We urge CMS to discontinue this tactic and permit ECs to score points in any of the Promoting Interoperability performance objectives and measures.

2015 CEHRT Requirement

CMS proposal (83 Fed. Reg. 35912, 35913): “However, beginning with the performance period in 2019, MIPS eligible clinicians must use EHR technology certified to the 2015 Edition certification criteria as specified at §414.1305. As discussed in this section, we continue to believe it is appropriate to require the use of 2015 Edition CEHRT beginning in CY 2019. In reviewing the state of health information technology, it is clear the 2014 Edition certification criterion are out of date and insufficient for clinician needs in the evolving health information technology (IT) industry....

“In working with ONC, we are able to identify the percentage of MIPS eligible clinicians that have a 2015 Edition of CEHRT available to them based on vendor readiness and information. As of the beginning of the first quarter of CY 2018, ONC confirmed that at least 66 percent of MIPS eligible clinicians have 2015 Edition CEHRT available based on previous Medicare and Medicaid EHR Incentive Programs attestation data. Based on these data, and as compared to the transition from 2011 Edition to 2014 Edition, it appears that the transition from the 2014 Edition to the 2015 Edition is on schedule for the performance period in CY 2019.”

MGMA comment: MGMA member practices are concerned with the unrealistic timeframe and the difficult-to-meet requirements proposed for the 2019 reporting year of the Promoting Interoperability component of MIPS, as well as with the potential related requirements under other areas of the QPP. ONC adopted an EHR software certification policy in 2011 that forced vendors to direct research and development resources toward meeting arbitrary government requirements and away from implementing end-user-friendly design. This regulatory-focused software certification environment has resulted in lost productivity, additional cost for practices to retool software to better meet their clinical and administrative needs and arguably had a negative impact on patient interactions.

Moving from 2014 Edition CEHRT to 2015 Edition CEHRT will be an onerous, costly, and challenging process for those physician practices who have not yet upgraded. EHR vendors are not required by law to recertify, and MGMA remains concerned that a significant percentage of the currently-certified products will not be recertified to the 2015 Edition standard given the substantial costs associated with developing, testing and rolling out this new product to customers.

Further, we contend the government’s estimate of full adoption by practices of 2015 Edition CEHRT by 2019 is overly optimistic and flawed. ONC’s own calculations indicate that, to date, only two thirds of ECs have moved to 2015 CEHRT, with the remainder currently using 2014 Edition software or not having adopted an EHR. For these ECs, we are concerned that the vendor has not (and may not) recertify to the 2015 Edition, forcing practices to “rip and replace” their software at great expense and impacting clinician productivity during the transition. Other ECs whose vendor does offer a 2015 Edition upgrade may lack the financial reserves to make the upgrade from their current version. Penalizing physician practices for not having the resources to upgrade or purchase expensive software was not the legislative intent of Congress when they enacted MACRA. We note that Congress also passed the Bipartisan Budget Act of 2018, which included a provision (Sec. 50413) aimed at reducing the volume of future EHR-related significant hardship exception requests by removing the increase of more stringent EHR-reporting program requirements.

As of this writing, based on data contained in the ONC Certified Health IT Product List, only 432 EHR products have been certified to the 2015 Edition compared with the 2,148 products listed by ONC as 2014 Edition certified. Note that the 432 EHR products certified at the 2015 Edition level is only a modest increase from the approximately 100 2015 Edition certified products at this time last year.

With quality reporting required to be full-year, many QPP participating practices that leverage their EHR software to report quality measures will need to have their EHR quality reporting dashboards in place by Jan. 1, 2019. Even for those ECs who do not use their EHR to report quality measures, it is unlikely that all EHR software vendors will be able to deliver systems in time for providers to test and deploy them by Oct.1, 2019, the start of the final 90-day Promoting Interoperability reporting period for the year. Without these systems in place and tested well before the start of a reporting period, providers face rushed implementations – increasing the potential for MIPS penalties, reducing administrative efficiencies gained by using HIT, and jeopardizing patient safety.

Should CMS adopt our recommendation to permit continued use of 2014 Edition CEHRT, we strongly urge you announce this flexibility as soon as possible and not wait until publication of the final rule in the late fall or early winter. On several occasions under the previous Administration, major modifications were made to the Meaningful Use Incentive Program that required changes to EHR software. Yet these program modifications were made very late in the calendar year, not allowing many practices and their vendor partners to take advantage of the flexibility to successfully meet program requirements that started the next calendar year.

If 2014 Edition CEHRT is not permitted to be used for the Promoting Interoperability component of MIPS, we urge flexibility. ECs who would be required to purchase their first EHR or upgrade from 2014 Edition CEHRT to 2015 Edition CEHRT but may not have the financial means, we recommend permitting them to submit a hardship exception and have the 25 Promoting Interoperability points moved to their Quality component score.

Scoring Methodology

CMS proposal (83 Fed. Reg. 35914-15): “We are proposing a new scoring methodology, beginning with the performance period in 2019, to include a combination of new measures, as well as the existing Promoting Interoperability performance category measures, broken into a smaller set of four objectives and scored based on performance. We believe this is an overhaul of the existing program requirements as it eliminates the concept of base and performance scores...If a MIPS eligible clinician fails to report on a required measure or claim an exclusion for a required measure if applicable, the clinician would receive a total score of zero for the Promoting Interoperability performance category... We also considered an alternative approach in which scoring would occur at the objective level, instead of the individual measure level, and MIPS eligible clinicians would be required to report on only one measure from each objective to earn a score for that objective. Under this scoring methodology, instead of six required measures, the MIPS eligible clinician total Promoting Interoperability performance category score would be based on only four measures, one measure from each objective. Each objective would be weighted similarly to how the objectives are weighted in our proposed methodology, and bonus points would be awarded for reporting any additional measures beyond the required four. We are seeking public comment on this alternative approach, and whether additional flexibilities should be considered, such as allowing MIPS eligible clinicians to select which measures to report on within an objective and how those objectives should be weighted, as well as whether additional scoring approaches or methodologies should be considered.”

MGMA comment: While we appreciate the intent to decrease the administrative challenges associated with ECs participating in the Promoting Interoperability component of MIPS, implementation of the proposed approach could act as a deterrent to EC participation and a roadblock to success of the program. By 2019, many clinicians would have been utilizing CEHRT for as many as eight years as part of a CMS incentive program, and perhaps even longer before the ONC certification process was put in place. Requiring objectives for the Promoting Interoperability score (Security Risk Analysis, e-Prescribing, Provider to Patient Exchange, and Health Information Exchange) adds an unnecessary burden for ECs and groups participating in MIPS. The Security Risk Analysis has been required by law since the HIPAA Security final rule was implemented in 2005. The remaining three objectives are fundamental functions of 2014 Edition and 2015 Edition CEHRT.

In order to maximize the ability of ECs or groups to leverage technology to meet multiple MIPS requirements, optimally those ECs attesting to successfully participating in one or more of the Improvement Activity options requiring the use of CEHRT or successfully reporting quality measures using CEHRT should be deemed to have met the Promoting Interoperability requirements and be awarded the full 25 Promoting Interoperability points.

Should this cross-category approach to meeting program requirements not be adopted, we recommend a methodology employed in the 2018 Advancing Care Information component of MIPS. The 2018 program established certain measures with a numerator of one – electronic prescribing and patient access. By doing so, the agency required the EC to attest not only to having 2014 or 2015 Edition CEHRT, but also the capability of using the features of the EHR being measured. We believe that this same approach could be adopted for the 2019 Promoting Interoperability reporting period and applied to other objectives. Removing the requirement for the EC to collect denominators and numerators will significantly decrease the administrative burden associated with this component of MIPS.

The 2019 Promoting Interoperability category should be simplified by creating the following approach:

Objective	Measure	Promoting Interoperability Points using 2015 CEHRT	Promoting Interoperability Points using 2014 CEHRT
Using 2015 CEHRT	Attest to having adopted 2015 CEHRT	20	-
e-Prescribing	Attest to have e-prescribed at least once during the reporting period	10	10
Provide Patients Electronic Access to their Health Information	Attest to have provided at least one patient electronic access to their health information	10	10
Conducting a Security Risk Analysis	Attest to have completed a Security Risk Analysis at least once during CY 2019	5	5
Secure Messaging	Attest to have sent or received at least one secure message (encrypted email for via secure web portal) during the reporting period	5	5

Health Information Exchange	Support Electronic Referral Loops by Sending Health Information. Attest to have sent at least one summary of care document in support of a transition of care or referral using CEHRT	20	30
Health Information Exchange	Support Electronic Referral Loops by Receiving and Incorporating Health Information. Attest to have received at least one summary of care document in support of a transition of care or referral using CEHRT	20	30
Public Health and Clinical Data Exchange	Clinician is in active engagement	10	10
e-Prescribing	Query of Prescription Drug Monitoring Program (PDMP). A numerator of at least one is required to fulfill this measure.	10 bonus points	10 bonus points
e-Prescribing	Verify Opioid Treatment Agreement. A numerator of at least one is required to fulfill this measure.	10 bonus points	10 bonus points

Regardless of what specific objectives and measures are adopted, for the 2019 reporting period CMS should apply the same 50-point scoring standard finalized for the 2019 Inpatient Meaningful Use Program to the MIPS Promoting Interoperability. Thus, ECs who earn 50 points or higher in MIPS Promoting Interoperability should be deemed to have satisfied the Promoting Interoperability category’s requirements. These ECs should receive 100 points in the Promoting Interoperability category, translating to 25 points towards an EC’s final composite score. ECs scoring 49.9 or fewer points should be scored according to their finalized Promoting Interoperability score (i.e., an EC scoring 30 Promoting Interoperability points would receive 7.5 MIPS composite score points).

The above approach would address several critical issues. First, the Promoting Interoperability component of MIPS would cease being an “all or nothing” approach with ECs able to select among the measures within an objective that best meet their clinical needs. This would permit them to score points in any of the categories-selecting measures that are most relevant to their patient population and within their control. Second, ECs would be incentivized to adopt 2015 Edition CEHRT with 20 points automatically added to their Promoting Interoperability score. ECs continuing to use 2014 Edition CEHRT would have those points moved to the health information exchange categories. Finally, we also believe that removing the administrative requirements associated with meeting superfluous objectives would be a further incentive for physician practices to adopt CEHRT.

For the 2020 reporting Promoting Interoperability period preferably ECs or group attesting to implementing 2015 Edition CEHRT and attesting that they have not turned off any of the Promoting Interoperability features, should be deemed to have met the Promoting Interoperability requirements and be awarded the full 25 Promoting Interoperability points. Adopting this approach would serve as a

significant incentive to upgrade from 2014 CEHRT or purchase 2015 CEHRT while at the same time avoids burdening clinicians with onerous requirements simply to establish that they are using EHR technology. Rather than have CMS and ONC dictate how ECs should leverage their technology to treat their patients, we urge these agencies to permit ECs to work directly with their EHR vendor and provider community to develop and implement the infrastructure and workflow necessary to effectively and efficiently exchange patient data.

Alternatively, for 2020, CMS should only require physicians to attest to meeting the program's measures—i.e., ECs should only be required to report “yes” or “no” on whether they had at least one patient in the numerator of each measure. Each “yes” would be worth whatever that measure's potential points are (e.g., under the current proposal, a “yes” attestation to e-prescribing would be worth 10 points). In addition to reducing reporting burden, a yes/no attestation-based approach would help facilitate EHR development to be more responsive to real-world patient and clinician needs, rather than designed simply to measure, track, and report. This will help close the gap in health IT functionality and usability.

CMS should also score physicians at the objective level—that is, scored based on reporting one measure from each objective and receiving bonus points for any additional reported measures. We oppose the agency's proposal requiring ECs to report on all measures to be deemed a “meaningful user” of the technology. Not all measures work for all practices, and ECs should be able to select among the measures within an objective on which they wish to report.

Further, CMS should require that health IT vendors, not ECs, report CEHRT functionality utilization levels. EHR software typically captures what functionalities are used to perform specific clinical tasks, permitting EHR vendors to aggregate the data and provide it to CMS and ONC. Requiring EHR vendors to provide information directly to CMS and ONC on the real-world use of technology will provide insight into an EHR's usability and conformance to certification.

Performance Scoring

CMS proposal (83 Fed. Reg. 35920, 36063): “We are proposing to adopt beginning with the performance period in 2019 the existing Promoting Interoperability objectives and measures as finalized in the CY 2018 Quality Payment Program final rule (82 FR 53674 through 53680) with several proposed changes as discussed herein, including the addition of new measures, removal of some of the existing measures, and modifications to the specifications of some of the existing measures.” CMS also proposed to simplify scoring by eliminating the concept of base and performance scores and focusing on a smaller set of measures which are scored on performance. To receive Promoting Interoperability points, ECs and group practices would have to strive for significant numerator thresholds for a number of required objectives. There are currently four such proposed measures, e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange.

MGMA comment: Three of these measures, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange, rely on the actions of a third party (e.g., patient, outside clinical setting, public health or exchange entity) for the EC to be successful. Recording a high score in a category that is within the EC's control (i.e., electronically prescribing patient medications) is far more achievable than recording a high score in a category such as exchanging data with an outside clinical setting. ECs should only be required to report their capability to meet an objective that requires third-party action.

In addition, smaller, rural, or specialty practices are inherently disadvantaged when it comes to achieving high scores for many of the Promoting Interoperability measures. For instance, medical specialties that traditionally do not have ongoing patient communication (i.e., a specialist who might see a patient only one time for a consult) would struggle to achieve high scores.

Measure Removal

CMS proposal (83 Fed. Reg. 35920): “Four of the measures—Patient-Specific Education; Secure Messaging; View, Download, or Transmit; and Patient-Generated Health Data—would be removed because they have proven burdensome to MIPS eligible clinicians in ways that were unintended and may.”

MGMA comment: We concur with the decision made by the agency to remove Patient-Specific Education, Secure Messaging, and Patient-Generated Health Data from the Promoting Interoperability objectives and agree that these measures are burdensome. More importantly, reporting these and other measures takes valuable time away from patient care and leads directly to increased clinician frustration and ultimately contributes to burnout. However, rather than stop at removing these measures, we urge CMS to closely review other 2019 proposed requirements and remove or reduce the reporting requirements for each of the remaining measures. Lastly, we note that although cited in the proposed rule as a measure removed from the program, “View, Download, or Transmit” has simply been renamed to be “Provide Patient Access” with ECs required to capture the same denominators and numerators.

e-Prescribing Measures

CMS proposal (83 Fed. Reg. 35914 359115): CMS introduce two optional measures for 2019: Query of PDMP and Verify Opioid Treatment Agreement. ECs would earn up to 5 bonus points for each measure in 2019. Beginning in 2020, these measures would be required and worth 5 points each. Recognizing that not all ECs would be able to e-prescribe controlled substances, CMS proposes an exclusion for any EC who is unable to report the measure in accordance with applicable law and the 5 points would be redistributed to the e-Prescribing measure.

MGMA comment: We agree that both the Query of Prescription Drug Monitoring Program and Verify Opioid Treatment Agreement measures should be optional for 2019. We oppose, however, making these required elements in 2020. As stated in the rule, one or both measures may not be available to all ECs in all parts of the country and vendors may not support them. Further, congressional action is expected on opioids, and legislative provisions may significantly impact these measures. We recommend the agency make, at a minimum, the Query of Prescription Drug Monitoring Program and Verify Opioid Treatment Agreement measures optional for the 2019 and 2020 reporting periods.

PDMP Query

CMS proposal (83 Fed. Reg. 35922-23): “Proposed Measure Description: For at least one Schedule II opioid electronically prescribed using CEHRT during the performance period, the MIPS eligible clinician uses data from CEHRT to conduct a query of a Prescription Drug Monitoring Program (PDMP) for prescription drug history, except where prohibited and in accordance with applicable law... Although the query of the PDMP may currently be burdensome for some MIPS eligible clinicians as part of their current workflow practice, we believe querying the PDMP is beneficial to optimal prescribing practices and foresee progression toward fully automated queries of the PDMP building upon the current initiatives at the State level... We seek comment on the challenges associated

with querying the PDMP with and without CEHRT integration and whether this proposed measure should require certain standards, methods or functionalities to minimize burden.”

MGMA comment: One of the tools most critically underutilized in the fight against the opioid epidemic is e-Prescribing. E-Prescribing of opioids would allow providers to flag potential overuse or misuse for patients more easily when prescribed by multiple practices or providers through real-time notifications. It would also facilitate the collection of data that could be studied and used to inform ongoing efforts to curb opioid overuse and misuse.

E-Prescribing of non-controlled substances was a required component of the Medicare and Medicaid Meaningful Use EHR Incentive Program and is currently required as part of the 2018 advancing care information (ACI) component of MIPS. As a result, a high percentage of physicians use this approach to prescribe medications for their patients. Unfortunately, e-Prescribing of controlled substances is obfuscated by a myriad of complex federal and state regulations and requirements that impose administrative burden on practices and prohibit more widespread adoption. With many physicians forced to write paper prescriptions for controlled substances, the ability to identify patient overuse or misuse is significantly decreased and hinders automated data collection.

For maximum effectiveness, efforts to incentivize e-Prescribing should be coupled with efforts to promote a nationally-accessible Prescription Drug Monitoring Program (PDMP). Currently, 45 states participate in the National Association of Boards of Pharmacy’s (NABP’s) prescription monitoring program (PMP) and data sharing system, NABP PMP InterConnect. This type of federated model allows states to retain control over their own databases while granting access to appropriately authorized physicians in other regions. This enables more effective treatment decisions and closes the loophole that exists when addicted patients seek new prescriptions across state lines. All remaining states should be encouraged to join this broad effort to communicate prescription information.

In addition, integration of this data into electronic health record systems should ensure that the physician has access to the data during the time of the patient encounter. Currently, some EHR PDMP interfaces permit the physician to access various state PDMPs, but each state must be clicked individually—meaning it is incredibly burdensome to search a patient’s prescribing history in multiple states at once. A more effective approach would be to have the patient’s PDMP records automatically combined from each state and presented to the physician in an easy to read format and available in real-time. This would allow the physician to engage with the patient during the encounter and take appropriate actions.

Congress is currently working on opioid legislation that could address issues related to e-Prescribing of controlled substances and PDMPs. We urge CMS to be as flexible as possible with the e-Prescribing and PDMP Promoting Interoperability measures and incorporate any applicable legislative changes into the Promoting Interoperability program. Further, in recognition of the importance of the query of PDMP measures, we urge the agency to increase the bonus points available to 10 points. Having the clinician query a PDMP, especially if the system reports data from the all or nearly all states and verifying the patient’s treatment agreement can have a dramatic impact on the nation’s opioid epidemic.

Verify Opioid Treatment Agreement Measure

CMS proposal (83 Fed. Reg. 35924): “We also understand from stakeholder feedback during listening sessions that there are varied opinions regarding opioid treatment agreements amongst health care providers. Some are supportive of their use, indicating that treatment agreements are an important part

of the prescription of opioids for pain management, and help patients understand their role and responsibilities for maintaining compliance with terms of the treatment. Other health care providers object to their use citing ethical concerns, and creation of division and trust issues in the health care provider–patient relationship. Other concerns stem from possible disconnect between the language and terminology used in the agreement and the level of comprehension on the part of the patient. Because of the debate among practitioners, we request comment on the challenges this proposed measure may create for MIPS eligible clinicians, how those challenges might be mitigated, and whether this measure should be included as part of the Promoting Interoperability performance category.”

MGMA comment: The CMS proposal cited above highlights the fact that the provider community has significantly varied positions regarding the clinical impact of opioid treatment agreements. In their 2010 [study](#), the American College of Physicians concluded that there was relatively weak evidence supporting the effectiveness of opioid treatment agreements in reducing opioid misuse by patients with chronic pain. Similarly, a 2013 AMA Journal of Ethics [article](#) stated that as these opioid contracts are often formatted like informed consent documents, they wondered whether a patient’s need for effective analgesia introduces an element of coercion. The authors suggested that perhaps a patient would agree to any requirements, no matter how burdensome, to obtain needed medication.

The AMA article also warned the use of narcotics contracts sends the inherent message to the patient that he or she cannot be trusted. Does a contract then fundamentally alter the fiduciary nature of the relationship between the doctor and patient? While the agreement document may contain language regarding shared goals, it is clear that the patient wants a medication that is perceived to be of benefit. The physician has the power to provide it but also may dictate the terms of provision. Physicians may frame the use of these contracts as tools to ensure patients’ safety when taking a high-risk medication, but it is important to note that similar contracts for other medications that pose substantive risks to patients are not employed.

With this level of clinical ambiguity, CMS should refrain from making the Verify Opioid Treatment Agreement a requirement of the Promoting Interoperability category of MIPS at any time. The decision of whether to leverage these agreements as part of the physician-patient treatment relationship should be left up to the clinical judgement of the physician.

e-Prescribing Exclusion

CMS proposal (83 Fed. Reg. 35915): “We are proposing that if the MIPS eligible clinician qualifies for the e-Prescribing exclusion and is excluded from reporting all three of the measures associated with the e-Prescribing objective as described in section III.H.3.h.(5)(f) of this proposed rule, the 15 points for the e-Prescribing objective would be redistributed evenly among the two measures associated with the Health Information Exchange objective and the Provide Patients Electronic Access to their Health Information measure by adding 5 points to each measure.”

MGMA comment: While we recommend that the Query of Prescription Drug Monitoring Program and Verify Opioid Treatment Agreement measures be optional in 2019 and beyond for reasons stated above, should CMS make these e-Prescribing measures requirements, it will be important to permit ECs appropriate exclusions. Should an EC qualify for an exclusion from reporting each of the e-Prescribing measures, the 15 points should be distributed to the Provider to Patient Exchange objective (10 points) and the Health Information Exchange objective (5 points).

CMS proposal (83 Fed. Reg. 35925): “Numerator: The number of unique patients in the denominator for whom the MIPS eligible clinician seeks to identify a signed opioid treatment agreement and, if identified, incorporates the agreement in CEHRT. A numerator of at least one is required to fulfill this

measure. Exclusion (beginning in 2020): Any MIPS eligible clinician who is unable to electronically prescribe Schedule II opioids in accordance with applicable law during the performance period. We propose that the exclusion criteria would be limited to prescriptions of Schedule II opioids as the measure action is limited to electronic prescriptions of Schedule II opioids only and does not include any other types of electronic prescriptions. We are requesting comment on the proposed exclusion criteria and whether there are additional circumstances that should be added to the exclusion criteria and what those circumstances might be including medical diagnoses such as cancer or patients under care of hospice.”

MGMA comment: While we agree with the proposed exclusion, we also recommend CMS allow the EC to apply for an exclusion from the Verify Opioid Treatment Agreement measure, if not made optional for the 2020 reporting year and beyond, should the EC believe these treatment agreements are not clinically appropriate. The 5 points should then be reassigned to the e-Prescribing measure.

Further, there are clinical situations where the provider-patient relationship or the nature of the patient’s illness does not require consultation of the PDMP nor verification of an opioid treatment agreement. These additional circumstances that should be added to the exclusion criteria could include long-established chronic illnesses or medical diagnoses such as cancer, post-surgical patients, or patients under care of hospice. The decision regarding which clinical situations to apply to exclusion criteria should be left solely to the discretion of the EC.

Security Risk Analysis

CMS proposal (83 Fed. Reg. 35916): “We propose that the Protect Patient Health Information objective and its associated measure, Security Risk Analysis, would remain part of the requirements for the Promoting Interoperability performance category, but would no longer be scored as a measure and would not contribute to the MIPS eligible clinician’s Promoting Interoperability performance category score.”

MGMA comment: Maintaining the privacy of protected health information and security of EHRs is part of the foundation of our healthcare system and has been outlined clearly through the legislative and regulatory processes. As such, providers, as HIPAA covered entities, are required to conduct risk analyses and mitigate any real or potential security vulnerabilities. Requiring an EC or group practice to conduct a security risk analysis that is already required under HIPAA is duplicative and only adds unnecessary reporting burden. An additional challenge to this objective has been the imprecise standard of what constitutes an acceptable “risk analysis.”

The HIPAA security regulation outlines the required process but does not specify the exact steps, milestones or expected outcomes of that analysis. Consequently, compliance with this requirement and fulfillment of this current Promoting Interoperability requirement has proven difficult, especially for smaller practices that typically have limited in-house expertise in this area. CMS should work with the Office for Civil Rights (OCR) to develop specific guidance and education on risk analysis and risk mitigation. In particular, we would encourage full transparency from those agencies that conduct audits of practice security processes and procedures. Having CMS (through Figliozi), OCR, and the Office of Inspector General provide comprehensive details of audit processes and de-identified findings will be essential for practices to understand the government’s risk analysis requirements and expectations.

We further recommend CMS provide physician practices with guidance on the various available security frameworks and how to implement them, to protect electronic PHI through administrative, physical and technical safeguards (as required under HIPAA). While many security frameworks exist,

the healthcare industry has not reached consensus in terms of a single approach. Practices need to have a clear benchmark for understanding the requirements in all these areas to ensure they have implemented an adequate security infrastructure.

Health Information Exchange Measures

CMS proposal (83 Fed. Reg. 35927): “We are proposing to add the following new measure for inclusion in the Health Information Exchange objective: Support Electronic Referral Loops by Receiving and Incorporating Health Information. This measure would build upon and replace the existing Request/ Accept Summary of Care and Clinical Information Reconciliation measures... We are proposing to combine two existing measures, the Request/Accept Summary of Care measure and the Clinical Information Reconciliation measure, in this new Support Electronic Referral Loops by Receiving and Incorporating Health Information measure to focus on the exchange of health care information as the current Clinical Information Reconciliation measure is not reliant on the exchange of health care information to complete the measure action. We are not proposing to change the actions associated with the existing measures; rather, we are proposing to combine the two measures to focus on the exchange of the health care information, reduce administrative burden, and streamline and simplify reporting.”

MGMA comment: Requiring an EC or group to report the Support Electronic Referral Loops by Receiving and Incorporating Health Information objective simply adds additional tasks for minimal value. The agency should seek to identify every opportunity to eliminate redundancy and administrative burdens associated with participation in the QPP. Again, by simply investing in 2014 Edition CEHRT, 2015 Edition CEHRT, or a combination of the two, the physician practice has provided sufficient evidence that they are leveraging this technology to deliver patient care and will utilize electronic referral loops where feasible and clinically appropriate.

Should the objective be required, MGMA also has concerns regarding what would constitute an acceptable “electronic” transmission related to an exchange of health information. Recognizing that each transmission method may require the practice to reconfigure workflows, we recommend CMS develop clear guidance to assist ECs in clearly understanding transmission options at the onset of the performance period. Additionally, we concur with the agency’s earlier contention that opening up the measure for alternative electronic delivery pathways could reduce administrative expense for ECs seeking to meet this measure, though we do not believe this flexibility will completely eliminate EC costs. We urge the agency to monitor ongoing EC transmission costs and burdens and modify this measure should evidence suggest ECs are being subjected to overly expensive or burdensome processes.

CMS proposal (83 Fed. Reg. 35926): “Accordingly, we are proposing that MIPS eligible clinicians may use any document template within the CCDA standard for purposes of the measures under the Health Information Exchange objective. While a MIPS eligible clinician’s CEHRT must be capable of sending the full CCDA upon request, we believe this additional flexibility will help support clinicians’ efforts to ensure the information supporting a transition is relevant.”

MGMA comment: We agree with the agency’s proposal to permit ECs to utilize any document template within the CCDA standard for exchanging health information. We have found that EHR vendors support different templates and ECs should not be required to incur the costs to modify or upgrade vendor-supplied CCDA templates to meet an arbitrary standard. Permitting this flexibility will allow ECs to work with their EHR vendors to determine which template would be the most appropriate (i.e., “consultation note” versus “referral note”) to their clinical situation and workflow.

CMS proposal (83 Fed. Reg. 35927): “Numerator: The number of electronic summary of care records in the denominator for which clinical information reconciliation is completed using CEHRT for the following three clinical information sets: (1) Medication—Review of the patient’s medication, including the name, dosage, frequency, and route of each medication; (2) Medication allergy— Review of the patient’s known medication allergies; and (3) Current Problem List—Review of the patient’s current and active diagnoses.”

MGMA comment: While we agree that there is value to the clinician receiving summary of care records using CEHRT, we disagree with the proposal to require the EC to capture each instance that the clinical information reconciliation occurs. The administrative burden required to record information for three clinical information sets – medications, medication allergies, and the patient’s current problem list – is substantial. We recommend moving back to a previous iteration of the program and require the EC to attest to have completed one clinical information reconciliation during the reporting period. CMS could also require the EC to attest that they have not turned off this EHR functionality. Adopting this approach would significantly reduce the administrative burden associated with this measure.

Health Information Exchange Measure Exclusion

CMS proposal (83 Fed. Reg. 35927): “Any MIPS eligible clinician who receives fewer than 100 transitions of care or referrals or has fewer than 100 encounters with patients never before encountered during the performance period.”

MGMA comment: We agree with the proposal to offer an exclusion for the transitions of care or referrals measures within the Health Information Exchange objective. These ECs seldom refer or transition patients and therefore may not be able to meet even a one patient threshold for this measure. CMS should, however, raise the exclusion thresholds to more accurately reflect physician practice operations. We would urge the Health Information Exchange threshold to be increased from fewer than 100 transitions of care or referrals during the performance period to fewer than 200 transitions of care or referrals.

Public Health and Clinical Data Registry Reporting

CMS proposal (83 Fed. Reg. 35929): “In connection with the scoring methodology proposed in section III.H.3.h.(5)(d) of this proposed rule, we are proposing changes to the Public Health and Clinical Data Registry Reporting objective and five associated measures. We believe that public health reporting through EHRs will extend the use of electronic reporting solutions to additional events and care processes, increase timeliness and efficiency of reporting and replace manual data entry.

“We further propose similar flexibility for MIPS eligible clinicians who choose to report the measures specified for the Public Health Reporting Objective of the 2018 Advancing Care Information Transition Objective and Measure set. We propose if a MIPS eligible clinician fulfills the Immunization Registry Reporting Measure, the MIPS eligible clinician would earn 10 percentage points in the performance score. If a MIPS eligible clinician cannot fulfill the Immunization Registry Reporting Measure, we are proposing that the MIPS eligible clinician could earn 5 percentage points in the performance score for each public health agency or specialized registry to which the clinician reports for the following measures, up to a maximum of 10 percentage points: Syndromic Surveillance Reporting; Specialized Registry Reporting. A MIPS eligible clinician who chooses to report to more than one specialized registry or public health agency to submit syndromic surveillance data may earn 5

percentage points in the performance score for reporting to each one, up to a maximum of 10 percentage points.”

MGMA comment: We support this proposal and concur that by proposing to expand options for fulfilling the Public Health Reporting objective, the agency is adding much needed flexibility so that additional MIPS ECs can successfully meet this objective and earn 10 percentage points in the performance score. However, we oppose the proposed “two-for-one” requirement that requires an EC to successfully report to two alternate public health agencies and/or registries for a value of only 5 points each. Due to the level of complexity and resource investment commonly associated with linking to and enabling reporting to public health agencies and/or registries, reporting to one other public health agency or registry should suffice. We recommend modifying this proposal to permit reporting to one alternate public health agency or registry to satisfy the requirements for immunization registry reporting.

Exclusions

CMS proposal (83 Fed. Reg. 35929): Measure: Immunization Registry Reporting. Proposed Exclusions: Any MIPS eligible clinician meeting one or more of the following criteria may be excluded from the Immunization Registry Reporting measure if the MIPS eligible clinician: 1. Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction’s immunization registry or immunization information system during the performance period. 2. Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the performance period. 3. Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of 6 months prior to the start of the performance period.”

MGMA comment: While we appreciate and agree with the three proposed exclusions being offered for ECs, we recommend that the first exclusion for Immunization Registry Reporting (“Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction’s immunization registry or immunization information system during the performance period”) be modified to 100 or less immunizations in a performance period to account for those ECs who perform a minimal number of immunizations. We agree with the additional proposed exclusions for Immunization Registry Reporting and the proposed exclusions for the remaining measures in the Public Health and Clinical Data Registry Reporting category.

Provide Patients Access Objective

CMS proposal (83 Fed. Reg. 36063): “For the Provider to Patient Exchange objective, we used the Provide Patient Access to View, Download, or Transmit measure to estimate performance for the proposed Provide Patients Electronic Access to Their Health Information measure.”

MGMA comment: It is important to note that MGMA members have experienced significant challenges with patients accessing clinical records using practice-supplied web portals for the current View, Download, or Transmit measure. Not only are there technical hurdles to overcome before the practice can deploy a patient portal that is both convenient for the patient and securely protects data, but an overwhelming percentage of patients never take advantage of the capability to view, download, or transmit their medical record. However, it is important to note that a much more significant number of patients leverage these web-based services for administrative tasks.

Relationships between certain medical specialties and clinics and their patients may not necessitate access to the medical record or benefit from electronic messaging through a web portal. Following what could be a short consultation with the EC, it could prove highly unlikely the patient would subsequently create an account and log into a portal to view, download, or transmit their medical record. Further, with ECs and group practices providing the patient with a summary of the visit, it again makes it unlikely the patient would leverage a web portal to access what could be the exact same information. In addition, the revised HIPAA Privacy regulations already require providers make available to the patient their record in an electronic format of the patient's choice, including having the practice email the patient their medical record. As a result, this particular requirement is not only unrealistic, but redundant.

As technology improves, patients are likely to become more engaged in their healthcare and seek online access to their health information. The industry, however, is not at the stage where high percentages of patients are requesting access to their medical record via these web services, particularly those in the Medicare population. At the same time, more and more patients want to leverage online functionalities when interacting with the healthcare system.

Our members report that patients are far more interested in utilizing other online administrative tools directly via a web portal such as appointment scheduling, prescription refill requests, reviewing and paying outstanding balances, completion of registration information, acknowledgement of receipt of the practice's HIPAA Notice of Privacy Practices, insurance-related information, and other required forms. We strongly recommend these administrative transactions be permitted to count toward the provide patient access numerators, including those that occurred prior to, or in lieu of, a face-to-face visit with the EC. By incentivizing and rewarding practices for encouraging patients to use this wider variety of online administrative services, it would be much easier to simultaneously encourage patients to also view, download or transmit their record or access secure messaging, thereby achieving higher levels of patient digital involvement.

Exception for MIPS ECs Using Decertified EHR Technology

CMS proposal (83 Fed. Reg. 36084): "Beginning with the 2020 MIPS payment year, the MIPS eligible clinician demonstrates through an application submitted to CMS that their CEHRT was decertified either during the performance period for the MIPS payment year or during the calendar year preceding the performance period for the MIPS payment year, and the MIPS eligible clinician made a good faith effort to adopt and implement another CEHRT in advance of the performance period. In no case may a MIPS eligible clinician be granted this exception for more than 5 years.

MGMA comment: As stipulated in the 21st Century Cures Act, ECs are permitted to apply for a hardship exception should their EHR be decertified by ONC. We support the CMS proposal to rely on this statutory provision to assign a zero percent weighting to Promoting Interoperability for ECs who demonstrate that reporting Promoting Interoperability measures is not possible because the CEHRT used was decertified. When a physician practice invests in an EHR that has been subsequently decertified and thus cannot be leveraged for MIPS participation, the process of determining next steps vis-à-vis technology will be long and complicated. Vendors who have been decertified may still attempt to be recertified and most likely will communicate this to their physician practice clients.

We are concerned, however, with the agency's requirement that the "MIPS eligible clinician made a good faith effort to adopt and implement another CEHRT in advance of the performance period." Typically, practices would prefer not to have to switch to a new EHR and therefore may lose significant time before initiating the process of selecting a new product. Further, once the practice does

decide that it must switch to another software product, that EHR selection process can take a significant amount of time – considerably longer than the “in advance of the performance period” identified in this proposed rule. To rush the selection and implementation of an EHR puts the practice at risk of not only impacting practice performance, but also patient safety. Also, when practices adopt an EHR, they often move to new practice management system software (usually an integrated product), which adds cost and time. These challenges are exacerbated in smaller practices with fewer resources to implement new software and train staff.

With these issues in mind, we urge the agency to remove the requirement that ECs make “a good faith effort to adopt and implement another CEHRT in advance of the performance period” and permit the EC to receive a hardship exception for as long as they require it and have their Promoting Interoperability performance category reweighted to zero.

ECs Facing a Significant Hardship

CMS proposal (83 Fed. Reg. 36030): “As established in the CY 2017 and CY 2018 Quality Payment Program final rules, MIPS eligible clinicians who meet the criteria for a significant hardship or other type of exception may submit an application requesting a zero percent weighting for the Promoting Interoperability performance category in the following circumstances: Insufficient internet connectivity, extreme and uncontrollable circumstances, lack of control over the availability of CEHRT, and decertified EHR technology (81 FR 77240 through 77243 and 82 FR 53680 through 53686).”

MGMA Comment: We support the proposed hardship exceptions and support the agency’s plan to re-weight the Promoting Interoperability category to zero. We also have the following comments and recommendations:

- Publish a definitive explanation for what constitutes “limited access,” and provide a list of all counties that have been identified by the Federal Communications Commission, or another agency, as having limited internet access.
- Expand the hardship exception for ECs and group practices who experience unforeseen circumstances that render it impossible to demonstrate the Promoting Interoperability requirements during the reporting period through no fault of their own to a minimum of five years after they begin experiencing these circumstances.
- Add a new hardship exception for ECs and group practices who have switched from one EHR product to another or experience significant difficulties with their EHR.
- Expand the hardship exception for ECs and group practices practicing for a limited period to allow them the additional time to identify, acquire and implement the most appropriate EHR technology. In addition, we recommend the exception be expanded to include those ECs and group practices who have changed specialty taxonomy.
- Grant ECs eligible for Social Security benefits a hardship exception and have them not be subject to any Medicare payment adjustment. Meeting the Promoting Interoperability requirements requires considerable expenditures of both human and financial capital, and the return on investment of an EHR installation to support MIPS likely will require several years of operation.
- Simplify the hardship exception application process by permitting multiple application submission options, including mail, fax and online capabilities. This would allow ECs and group practices additional flexibility for submitting applications.
- Provide email receipt confirmation once a hardship application has been submitted by an EC. This would avoid the situation that some of our members have encountered, where they find

out only after the hardship exception deadline has passed that the application was never officially received by CMS.

Issue: Continued monitoring of the EHR marketplace

Section 3007 (a) of the American Recovery and Reinvestment Act states:

“The National Coordinator shall support the development and routine updating of qualified EHR technology ... and make available such qualified EHR technology unless the Secretary determines through an assessment that the needs and demands of providers are being substantially and adequately met through the marketplace.”

We encourage the close and aggressive monitoring of the EHR marketplace by ONC to ensure that appropriate and cost-efficient products are being offered in a timely manner to physician practices, particularly small practices with limited financial resources. We also encourage early recognition by the ONC of marketplace failures and required subsequent deployment of low-cost alternative software.

We recommend that CMS, in partnership with ONC, continue to monitor the industry to ensure that: (a) there are a sufficient number of certified EHR products to meet the needs of all ECs and group practices of all sizes; (b) bottlenecks and order backlogs caused by delayed software development or certification would not prevent ECs and group practices from obtaining and implementing appropriate products in a timely manner; (c) EHR vendors that were 2014 certified would be certifying for 2015 certification as well, and (d) EHR product pricing would not prevent large numbers of ECs and group practices from participating in MIPS. In addition, we urge HHS to aggressively monitor the EHR vendor sector, establishing toll-free telephone numbers and a website allowing physician practices and others to report problems, issues, data blocking, and unfair business practices, for which we have come to understand is unfortunately a major issue for many of our members.

Issue: Data Blocking Attestation Requirement

In the 2017 final rule, ECs and group practices were required to attest they have cooperated in good faith with surveillance and direct review of their HIT certification by ONC. Such cooperation would include responding in a timely manner and in good faith to requests for information (i.e., telephone inquiries, written surveys) about the performance of the CEHRT capabilities in use by the provider in the field. In addition, ECs and groups are required to attest to three statements related to health information exchange and the prevention of health information blocking. CMS, in October 2017, released a [fact sheet](#) outlining additional specifics regarding the three statement and providing examples.

MGMA comment: We understand the intention of this requirement and applaud the government for seeking to reduce the number of data blocking occurrences and increase surveillance of EHR products. However, we assert that EC and group attestation as a requirement of MIPS participation is not the appropriate vehicle for achieving this goal. ECs, especially those in smaller practices, have little or no influence over the actions their EHR vendors take, nor do they typically have insight into the data sharing policies of vendors or downstream provider organizations. As with each of the MACRA regulatory requirements, ECs and group practices should only be responsible for the actions that they have direct control over. In addition, we are concerned that effectively defining “data blocking” is extremely challenging. For example, a provider who cannot afford interface technology linking their EHR to a local Health Information Exchange or inpatient facility should not be deemed guilty of data blocking. Further, ONC is expected to release a proposed rule on the issue of data blocking, and ECs

should not be required to attest to statements that could be explained, modified or, eliminated in a final rule issued from another agency.

MGMA urges CMS to eliminate this arbitrary attestation requirement and to provide additional information to the provider community regarding how to identify and avoid, whenever possible, instances of data blocking. This would include developing checklists and distributing questions that ECs can work with their EHR and interface vendors, as well as their provider exchange partners, to develop appropriate data exchange policies.

MIPS scoring system and aggregate requirements

Multi-category credit

CMS proposal (83 Fed. Reg. 35932): CMS states the agency has “looked extensively at ways to link three of the performance categories – quality, improvement activities and Promoting Interoperability – to reduce burden and create a more cohesive and closely linked MIPS program.” In particular, the agency has identified the possibility of creating multi-category measures that would cut across the different performance categories and allow MIPS ECs to report once for credit in all three performance categories. “For example, one possible combined measure would bring together the elements of the proposed Promoting Interoperability measure, Support Electronic Referral Loops by Sending Health Information, the improvement activity, implementation of use of specialist reports back to referring clinician or group to close referral loop, and the quality measure, Closing the Referral Loop: Receipt of Specialist Report.”

Additionally, CMS plans to propose in future rulemaking MIPS public health priority sets across four performance categories (quality, improvement activities, Promoting Interoperability, and cost). The agency would focus on creating public health priority sets for opioids, blood pressure, diabetes, and general health. CMS seeks comment about a public health priority set emphasizing the use of common health IT functionalities.

MGMA comment: MGMA strongly supports a multi-category reporting and scoring option in the MIPS program. With MACRA, Congress set out to streamline and harmonize existing quality reporting programs; we can think of no clearer way to satisfy congressional intent than to award credit across multiple MIPS performance categories for high-impact behavior. However, the current scoring system requires many clinicians to perform activities in multiple categories that are not relevant to their practice or risk failing the MIPS program. Taking the MIPS proposals in aggregate, group practices and ECs must generally juggle 16 measures to fully participate in MIPS, including six quality measures, two cost measures, two IAs, and six Promoting Interoperability measures.

MGMA collaborated with the American Medical Association and a workgroup of medical specialty societies and state medical associations to draft potential refinements to MIPS, including a multi-category credit pathway to success in MIPS. The primary goal of the scoring approach is to reduce administrative complexity to allow physicians and group practices to spend less time on reporting and more time with patients and on improving care, and to create a more sustainable MIPS program. The proposal aims to remove the category silos and harmonize the four categories to produce a more cohesive and holistic program and sharpen the focus on outcomes as opposed to just reporting. It also creates a glide path towards participation in MIPS APMs and Advanced APMs by encouraging physicians to focus reporting on more clinically relevant measures and activities, improvement, and providing better value care to patients.

We believe allowing physicians to focus on activities that fit within their workflow and address their patient population needs—and providing them with credit for those activities that span across the MIPS categories—will encourage increased participation and relevancy of MIPS and drive participation and continued improvement across categories. It would also facilitate the development of new measures and activities that addresses key gap areas such as patient-reported outcomes (PROs), leverage health information technology in a more meaningful way, and target key cost drivers through activities such as using CDS clinical decision support (CDS) and AUC.

This multi-category credit could also reduce the frequency with which categories such as promoting interoperability and cost would need to be reweighted. For example, allowing physicians who report or attest to measures and activities in the quality, promoting interoperability, and improvement activities categories to also earn points in the cost category decreases the likelihood that cost would need to be reweighted to quality. This approach could allow more physicians to demonstrate performance in cost while we wait for applicable episode-based measures to be completed and would link all four categories in a way that is relevant and actionable.

CMS could identify and prioritize the activities that qualify for multi-category credit on the QPP website through color coding or some sort of flag. At a minimum, multi-category credits should apply to the cost category since it has the fewest number of measures and is more of an unknown in terms of whether a physician or group will have a cost measure attributed to them.

The three examples below demonstrate how an EC or group would get credit for one measure or activity across multiple categories.

Example 1

A practice focuses on implementing patient-reported outcome into their care:

- Reports on a PRO measure, MIPS #398 (Varicose vein treatment with saphenous ablation: outcome survey) using an electronic health record (EHR) and patient portal
- Does not have any applicable cost measures
- Attests to the IA_BE_1 (Use of certified EHR to capture patient reported outcome)
- Attests to PI_PPHI_1 (Security risk analysis), PI_EP_1 (e-prescribing), PI_HIE_1 (Send a summary of care), PI_HIE_2 (Request/accept summary of care), and PI_CCTPE_3 measure (Patient-generated health data)

As a result, points by activity or measure would be achieved in the following categories:

Quality	Cost	Promoting Interoperability	IA
MIPS #398 IA_BE_1 PI_CCTPE_3	Rewighted to Quality	PI_PPHI_1 PI_EP_1 PI_HIE_1 PI_HIE_2 PI_CCTPE_3 MIPS #398 IA_BE_1	IA_BE_1 MIPS #398 PI_CCTPE_3

Example 2

A practice focuses on prevention and shared decision making around treatment for patients with Hepatitis C:

- Reports on MIPS # 387 (Annual hepatitis C virus screening for patients who are active injection drug users) and #390 (Hepatitis C: Discussion and shared decision making surrounding treatment options)
- Meets the case minimum for Total Cost of Care
- Attests to IA_CC_1 (Implementation of use of specialist reports back to referring clinician or group to close referral loop), IA_CC_2 (Implementation of improvements that contribute to more timely communication of test results), and IA_PM_14 (Implementation of methodologies for improvements in longitudinal care management for high risk patients)
- Attests to PI_PPHI_1 (Security risk analysis), PI_EP_1 (e-prescribing), PI_HIE_1 (Send a summary of care), PI_HIE_2 (Request/accept summary of care), PI_CCTPE_1 (View, Download and Transmit [VDT]), and PI CCTPE_2 (Secure Messaging).

As a result, points by activity or measure would be achieved in the following categories:

Quality	Cost	Promoting Interoperability	IA
MIPS #387	TCC	PI_PPHI_1	IA_CC_1
MIPS #390		PI_EP_1	IA_CC_2
IA_CC_1		PI_CCTPE_1	IA_PM_14
IA_CC_2		PI_CCTPE_2	MIPS #387
IA_PM_14		PI_HIE_1	MIPS #390
PI_CCTPE_1		PI_HIE_2	PI_CCTPE_1
PI_CCTPE_2		MIPS #387	PI_CCTPE_2
PI_HIE_1		MIPS #390	PI_HIE_1
PI_HIE_2		IA_CC_1	PI_HIE_2
		IA_CC_2	
	IA_PM_14		

Example 3

A cardiology practice focuses on appropriate use:

- Reports on MIPS #323 (Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention [PCI]) and MIPS #324 (Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients)
- Meets the case minimum for Total Cost of Care
- Attests to IA_PM_13 (Chronic care and preventative care management for empanelled patients) and IA_PSPA_17 (Implementation of analytic capabilities to manage total cost of care for practice population)
- Attests to PI_PPHI_1 (Security risk analysis), PI_EP_1 (e-prescribing), PI_HIE_1 (Send a summary of care), PI_HIE_2 (Request/accept summary of care), and PI_PEA_2 (Patient-specific education)

As a result, points by activity or measure would be achieved in the following categories:

Quality	Cost	Promoting Interoperability	IA
MIPS #323	TCC	PI_PPHI_1	IA_PM_13
MIPS #324	MIPS #323	PI_EP_1	IA_PSPA_17
TCC	MIPS #324	PI_HIE_1	MIPS #323
IA_PM_13	IA_PM_13	PI_HIE_2	MIPS #324
IA_PSPA_17	IA_PSPA_17	PI_PEA_2	TCC

MIPS targeted topics

While the goal of allowing participants to receive credit across categories simplifies and increases the relevancy of each category, what measures and/or activities can be used will need to be clearly outlined. Targeted topic areas can address priority items for CMS and the Administration. Below we provide four examples of how CMS could present information in targeted topics for participants to use and develop focused activities with the goal of improving patient care and achieve the highest MIPS score possible.

Health Information Technology (Health IT)-driven Patient-reported Outcomes Targeted Topic

- Quality: MIPS #219, 220, 221, 222, 223, or 398
- IA_BE_1 (Use of certified EHR to capture patient reported outcomes)
- PI_PPHI_1 (Security risk analysis), ACI_EP_1 (e-prescribing), PI_HIE_1 (Send a summary of care), PI_HIE_2 (Request/accept summary of care), and PI_CCTPE_3 (Patient-generated health data)

Diabetes Care Targeted Topic

- Quality: MIPS#1 (Diabetes: Hemoglobin A1c (HbA1c) poor control [$>9.0\%$]), MIPS #56 (Diabetes: foot exam), and MIPS #117 (Diabetes: eye exam)
- IA_BE_1 (Use of certified EHR to capture patient reported outcomes (for HbA1c monitoring) and IA_BE_4 (Engagement of patients through implementation of improvements in patient portal)
- PI_PPHI_1 (Security risk analysis), PI_EP_1 (e-prescribing), PI_HIE_1 (Send a summary of care), PI_HIE_2 (Request/accept summary of care), and PI_CCTPE_1 (View, Download and Transmit [VDT]), PI_CCTPE_2 (Secure Messaging), and PI_CCTPE_3 (Patient-generated health data) (for HbA1c monitoring)

Patient-centered Medical Home (PCMH) Targeted Topic

For practices that are a PCMH, each would:

- Report relevant quality measures
- Receive full credit for IA with no additional IA activities required
- Receive full credit for Promoting Interoperability as long as 50% were EHR users with no additional Promoting Interoperability activities required.

Qualified Clinical Data Registry (QCDR) Targeted Topic

- Reports quality measures through a QCDR
- Receive full credit for IA with no additional IA activities required
- Receive full credit for Promoting Interoperability as long as the participant attests to PI_PPHI_1 (Security risk analysis), PI_EP_1 (e-prescribing), PI_HIE_1 (Send a summary of care), PI_HIE_2 (Request/accept summary of care) with no additional Promoting Interoperability activities required.

Performance threshold

CMS proposal (82 Fed. Reg. 30147): CMS proposes to increase the performance threshold from 15 to 30 points for the 2019 performance period. Scores above 30 points would qualify for a MIPS bonus, while scores below the threshold would receive a penalty. The agency also proposes to increase the performance threshold for exceptional performers from 70 to 80 points.

MGMA comment: In the Bipartisan Budget Act of 2018, Congress recognized the importance of allowing a gradual ramp-up to full MIPS participation. As intended by Congress, CMS should maintain an achievable performance threshold until the program matures and implements sufficient, reliable, clinically relevant metrics that justify upward, and especially downward, payment adjustments for ECs and groups. Currently, the program remains largely an extension of the legacy programs Congress sought to retire through MACRA. Moreover, CMS proposes to expand MIPS to include a new cohort of clinicians in 2019.

While the agency expands MIPS to new clinicians, develops episode-based cost measures, creates multi-category measure sets, and restructures the entire promoting interoperability category, it should permit ECs and groups the flexibility to continue refining their MIPS participation strategy accordingly without the threat of penalty for falling below an unreasonable scoring threshold.

Significantly, ECs and group practices only learned about their performance in the first year of MIPS midway through 2018, and CMS does not anticipate releasing aggregate performance data via the MIPS Experience Report until fall 2018. We believe the benefits of maintaining an achievable threshold far outweigh the costs of prematurely increasing the threshold. Further, MGMA strongly urges CMS to gradually increase the performance threshold in 2019 so group practices and physicians may continue to gain experience with the new program criteria and convert feedback to improved performance within the program before being subject to harmful penalties.

Reporting within one performance category via multiple submission mechanisms

CMS proposal (83 Fed. Reg. 35952-53): CMS provides Table 48 as an example of how the agency will score quality measure points and bonus points for individual ECs who submit measures across multiple submission types. The agency also provides, “[w]e do not propose any changes to our policy regarding scoring measure achievement points and bonus points when using multiple collection types for non-Web Interface MIPS eligible clinicians in the quality performance category for the 2019 performance period.”

MGMA comment: MGMA supports the increased flexibility that would allow reporting quality measures across multiple data submission mechanisms. We regularly hear from physician group practices that although there may be six clinically-applicable quality measures, they are not all available using one submission mechanism. For group practices and ECs that take advantage of this reporting flexibility, we urge CMS to calculate performance by taking the highest score for any submitted measures, regardless of how the measure is submitted.

We also request clarification that this policy applies not just to individual ECs but also to group practices who choose to report quality measures across different submission mechanisms, such as EHR and registry. We also urge CMS to extend this policy beyond the quality performance category and allow ECs and groups to submit data on measures and activities in all categories, including Promoting Interoperability and improvement activities, using multiple data submission mechanisms.

Facility-based measurement

CMS proposal (83 Fed. Reg. 35956): CMS proposes a facility-based measurement option for clinicians who perform at least 75% of their services in the hospital inpatient, outpatient or emergency room setting and groups with 75% or more of such clinicians. The agency would calculate the quality and cost scores for interested facility-based clinicians and groups using a hospital’s performance in the Medicare Hospital Value-Based Purchasing (VBP) program.

MGMA comment: MGMA appreciates CMS' efforts to streamline and coordinate the quality reporting programs across sites of service and to give credit for existing quality improvement performance where performance is largely directed by hospital-based physicians. Because hospitals and other facilities are already collecting this data, a voluntary facility-based measurement option has the potential to reduce duplicative data collection, which would result in administrative simplifications across the Medicare program and encourage care coordination. MGMA urges CMS to ensure that the performance measurements are clinically relevant and to coordinate with the applicable medical specialties to incorporate appropriate attribution, risk adjustment and other factors that may impact performance. Similar to the low volume threshold opt-in, eligible ECs and group practices have an opportunity to elect facility-based measurement rather than automatically be attributed the score of the applicable facility setting.

Advanced APMs

MGMA urges CMS to expand the Advanced APM pathway in 2019 and welcomes the opportunity to work with the agency toward this common goal. CMS does not propose to add a single new APM to the list of Advanced APMs for the 2019 performance year. Moreover, HHS' tepid response to the thoroughly vetted recommendations from PTAC has been frustrating, not only for the inventors of the innovative models submitted for consideration, but also for the many medical groups and specialties that lack a single opportunity to join an Advanced APM. These actions are particularly concerning because MACRA provides only six year of bonus payments to facilitate physician practices' migration to APMs. We are approaching the three-year mark for the initial implementation, and there is still not a robust APM pathway for physician practices.

We believe there are several immediate steps the agency should take to expand the Advanced APM pathway. For instance, CMS should consider the MAQI demonstration a pathway to Advanced APM status and implement the physician-led APMs proposed by front-line providers and recommended by PTAC. We look forward to continuing to work with the agency to achieve our shared goal of supporting physician group practices as they transform their care delivery from volume-based to value-based.

Use of CEHRT

CMS proposal (83 Fed. Reg. 35990): CMS proposes to amend the qualifications for Advanced APMs beginning in 2019. If finalized, APMs must require at least 75% of ECs in each APM Entity use CEHRT to document and communicate clinical care with patients and other health care professionals. This would be an increase from the current 50% threshold for CEHRT use.

MGMA comment: MGMA recommends that new CEHRT requirements for Medicare APMs be deferred to 2020 like Other Payer APMs. Physician practices are already making plans to upgrade to 2015 edition CEHRT; physicians participating in APMs should not face too many new health information technology (health IT) requirements in a single year. Further, as described in detail above, MGMA is concerned that physician practices, including those participating in APMs, have little to no control over their EHR's ability to help achieve the goals of the QPP and the APM specifically. Health IT companies frequency charge fees for each and every requirement imposed by federal reporting programs. Vendors should be held accountable for producing tools to advance care outcomes without burdening physician practices or APMs with exorbitant fees and lack of usability.

Extending the current revenue-based nominal amount standard

CMS proposal (83 Fed. Reg. 35992): The revenue-based nominal amount standard for Advanced APMs other than medical home models would be maintained at the current level of 8% of average estimated total Medicare Parts A and B revenue through the 2024 qualified participant (QP) performance periods.

MGMA comment: MGMA agrees that the nominal amount standard should not increase above 8% to ensure stability and predictability for ECs and group practices moving into the Advanced APM pathway. CMS has never provided its methodologies for arriving at this 8% figure for the nominal amount standard, and MGMA, along with many other stakeholders, have repeatedly asserted that 8% in fact represents levels of risk substantially beyond “more than nominal.” Additionally, we remind CMS that Advanced APM Entities will already be facing increasing risk levels due to the statutory Advanced APM participation threshold, which will triple over the course of just a few years. This already represents a substantial increase in risk levels and increasing the nominal amount standard at the same time would likely become too high a barrier for many Advanced APM Entities to overcome and could lead to drastic cuts in participation in value-based payment models.

All-Payer Combination Option QP determination

CMS proposal (83 Fed. Reg. 36002): CMS proposes to add a third option to assess whether physicians have met the All-Payer threshold for Qualified APM Participants at the practice level (TIN), in addition to the individual level and the APM Entity level. CMS also clarifies that participants can meet Medicare and other payer APM participation thresholds using patient counts for one threshold and payment counts the other threshold, whichever is most advantageous to the EC or group practice.

MGMA comment: MGMA appreciates CMS’ recognition that other payers often contract with Advanced APM participants at the group practice level and that it is typically the group, not the EC, that is accountable for performance and risk. Importantly, one of the biggest advantages to the APM structure is that it allows for more flexibility and variation in design so that a wider range of practice types can succeed in value-based reimbursement models. It is problematic for CMS to undercut this very principle when it comes to making its own QP determinations. CMS should not seek to inhibit itself with unnecessary restrictions. Rather, it should give itself as much discretion as possible so that it can consider the unique design elements of each model to make QP determinations at the most appropriate level. Certainly, there will be some cases like the one CMS describes in the proposed rule in which it makes the most sense to make QP determinations at an individual clinician level. However, there will be just as many, if not more scenarios where participation decisions are required at the TIN-level, just as CMS requires participation at the TIN-level for certain Medicare APMs. To arbitrarily require QP determinations for these types of models be meticulously calculated for every individual clinician would be nonsensical and waste CMS’ time and money. CMS has already set a precedent in valuing flexibility by conducting MIPS scoring at varying levels, at the individual clinician, TIN or APM Entity levels.

MGMA urges the agency to mirror this existing policy and have APM Entities or participants elect to be evaluated at the clinician, practice or APM Entity level and have this determination status applied to all participating clinicians. Doing so would still allow CMS to make calculations at the clinician level if that is what is most appropriate but would not force the agency to do so in every case when it would make no logical sense. Particularly with the initial rounds of All-Payer QP determinations, it is important CMS start with a more flexible approach and learn through experience which changes, or additional restrictions, may prove effective and address this as necessary through future rulemaking.

Conclusion

We appreciate the opportunity to share our comments regarding the proposed changes to the Medicare Physician Fee Schedule and Quality Payment Program and to offer recommendations to improve and simplify these policies to support group practices as they care for patients. Should you have any questions, please contact Jennifer McLaughlin at jmclaughlin@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs

APPENDIX A

EVALUATION AND MANAGEMENT (E/M) SERVICES: REDUCING BURDEN IN DOCUMENTATION GUIDELINES

To assist as CMS undertakes this E/M reform initiative, MGMA has developed a set of principles outlined below. MGMA agrees there is significant opportunity to eliminate needless documentation requirements for billing an E/M visit code and recommends CMS engage stakeholders, including physician practice leaders, in a transparent process to achieve our shared goal of reducing burden in the E/M guidelines. As Medicare transitions from fee-for-service toward a value-based system and physicians take on more accountability for their resource use, the cognitive care furnished during E/M services—often the bedrock for the physician-patient relationship—has increasing importance.

- **Medical necessity should guide documentation requirements.**
 - The medical note should address the chief complaint that brought a patient in to the practice and how their care plan was decided.
 - While the presenting problem and medical decision-making involved in the E/M visit should be documented according to standard guidelines, other elements of the visit should be at the discretion of the practitioner.
 - Past, family and social history, though pertinent, may be effectively monitored at pre-determined intervals, akin to preventive services (i.e., bi-annual history reviews).
- **E/M coding guidelines must be simplified.**
 - Ambiguity about the appropriate level of E/M service should be reduced. Both the 1995 and 1997 guidelines leave significant room for interpretation, resulting in disagreements among coding experts and physicians about the appropriate code in certain circumstances.
- **CMS' effort to reduce documentation burden must be budget neutral.**
 - Simplification of the E/M documentation guidelines should not come at the cost of lower reimbursement.
 - Reducing the administrative complexity of billing E/M services should not be used as a means to reduce reimbursement for physicians.
- **Documentation changes should not be payer-specific.**
 - Physicians should not be required to change their coding and documentation workflow depending on the specific payer requirements for the patients they are seeing.
 - CMS should work with the American Medical Association Current Procedural Terminology (CPT) Editorial Panel and other stakeholders to align CMS' efforts and the documentation guidelines with CPT E/M codes, descriptions and guidelines.
- **E/M coding guidelines should not overemphasize face-to-face time.**
 - Moving to a time-based approach for billing E/M services may fail to capture the important nuances of many of the physician-patient counseling and interactions reflected in the wide array of office visits billed as an E/M code.
 - Face-to-face time between the practitioner and the patient does not fully reflect the complexity and medical decision-making inherent to providing these services. For instance, physicians perform non-face-to-face work to prepare for the visit, such as reviewing test results, and after the visit, such as coordinating with other physicians.

- Physicians and staff routinely explain test results and follow-up treatment options by telephone following the in-person visit. These non-face-to-face components of an E/M visit should be given consideration in developing new E/M guidelines.
- Documenting face-to-face time during an E/M visit would be administratively onerous and would raise challenges related to ensuring accuracy.
- **E/M documentation guidelines should reflect team-based care.**
 - Members of the patient's care team, such as a care manager or family member, or the patient if appropriate, should be expressly permitted to record information in the medical record. The physician could confirm or supplement that information by simple notation.
- **E/M documentation and audit guidelines should be consistent.**
 - CMS should work with HHS Office of Inspector General (OIG) to ensure the E/M documentation requirements provide auditors with the information needed to ensure the right level of care was provided and billed for and that E/M audit and documentation guidelines are consistent.
 - During the transition from the current guidelines to the new documentation requirements, there should be a significant grace period to ensure providers are not audited or penalized while they are implementing the new documentation guidelines. The transition from ICD-9 to ICD-10 could serve as an example of an appropriate grace period during the transition.
 - CMS should undertake a significant education and outreach campaign to inform practitioners and medical practice leaders about E/M documentation changes.
- **CMS' efforts should be part of a broader effort to reduce unnecessary documentation.**
 - Although the CMS E/M documentation guidelines' ambiguity and complexity increase unnecessary documentation, other factors contribute to over-documentation. These include quality measurement documentation requirements, prior authorization requests, risk adjustment considerations, and medical liability concerns. CMS must address these interrelated causes of unnecessary documentation to reduce provider burden.