



September 20, 2019

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; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies and the Quality Payment 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; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies,” published on August 14, 2019, with file code CMS–1715—P.

MGMA is the premier association for professionals who lead medical practices. 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 45,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 practices of all sizes, types, structures, and specialties that deliver almost half of the healthcare in the United States.

Key Recommendations

MGMA appreciates CMS’ leadership in improving Medicare and respectfully offers the following recommendations to assist CMS in achieving its goals of reducing clinician burden and improving patient care. In summary, we encourage the agency to:

- **Finalize the proposal to maintain separate payment rates for E/M visit levels** for established patients and reduce the number of levels for new patients by deleting CPT code 99201. We appreciate CMS’ proposal to revise the previously finalized E/M payment changes and align them with the CPT/RUC recommendations.
- **Finalize changes to E/M documentation requirements** that permit clinicians to choose the E/M visit level based on either medical decision making or time. We support this proposal and urge CMS to offer education surrounding any new documentation requirements.
- **Improve access to chronic care management (CCM) services.** Services such as CCM enhance Medicare beneficiary care management and help prevent adverse events, such as unnecessary hospital readmissions. We appreciate efforts in the proposal to improve payment accuracy through the creation of an add-on code for non-complex CCM services. However, rather than create new G-codes for existing CCM services, MGMA urges CMS to work with the CPT editorial panel on CPT revisions to avoid unnecessary confusion transitioning back to G-codes.

- **Continue to solicit stakeholder feedback through engagement opportunities around the Merit-based Incentive Payment System (MIPS) Value Pathways proposal.** We are encouraged by CMS’ proposal to create the MIPS Value Pathways (MVP) reporting approach and believe this is a step in the right direction toward a more streamlined, simplified quality program that has the potential to align the four reporting categories of MIPS. We have concerns, however, around particular aspects of CMS’ high-level framework, including assignment, any focus on population health measures, and the continued silo-ed approach to the improvement activities and promoting interoperability categories. In order to gather sufficient feedback and information from stakeholder groups and clinicians before proposing more detailed policies for MVP implementation, MGMA encourages CMS to continue to engage with the physician community following the comment period through in-person events, listening sessions, and other opportunities.
- **Stabilize the MIPS quality performance category** by maintaining current data completeness thresholds for longer than a single performance year. We urge CMS not to move forward with its proposal to increase the quality measure data completeness threshold to 70% in 2020. Further improvements to the category include eliminating the outcome or high-priority measure requirement, removing the administrative claims measure, and maintaining “topped out” measures. We oppose CMS’ proposal to remove quality measures with low reporting rates after two years, as this policy has the potential to discourage the development of new quality measures.
- **Prioritize methodological improvements to the MIPS cost performance category before increasing its weight.** While we support the move to episode-based measures, CMS is proposing to add 10 new measures this year, on top of eight new measures added last year. The agency also proposes to significantly revise the total cost of care (TPCC) and Medicare Spending per Beneficiary (MSPB) measures. While we ultimately believe these measures should be retired, should they be retained for the 2020 performance period we recommend refinements to avoid holding clinicians accountable for costs beyond their control.
- **Avoid adding complexity to the improvement activity performance category** by continuing to allow clinicians and groups to attest to completion of activities and not requiring a minimum participation threshold such as the 50% threshold for group practices proposed for 2020 implementation.
- **Increase opportunities to participate in Advanced Alternative Payment Models (APMs).** We appreciate announcements in April and July 2019 to create new Advanced APMs and encourage CMS to continue serious consideration and implement the physician-led APMs proposed by front-line providers and recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

Physician Fee Schedule

E/M Services

There is consensus among the physician community that excessive E/M documentation requirements take time away from patient care and make it difficult to locate critically necessary medical information in patients’ records, impeding the ability to provide high quality care. MGMA appreciates that CMS listened to the physician community and set forth policy changes in the proposed rule that would eliminate some of these documentation burdens. While we appreciate CMS’ efforts to simplify the add-on codes finalized last year, we have reservations around the proposed add-on codes, as articulated in greater detail below.

MGMA is particularly grateful that CMS proposes to eliminate the policy that would have collapsed payment rates for E/M levels 2 through 5 starting in CY 2021. Instead, CMS proposes to generally maintain separate payment rates for all E/M level visits in CY 2021.

To fully evaluate the impact of these proposals, MGMA requests clarification regarding the following frequently asked questions we have received from members:

- When selecting visit levels based on medical decision making (MDM), how should practitioners document their decisions?
- What would constitute as “medically necessary” to justify utilizing history and exam for selecting visit levels?
- Did CMS consider alternatives to the proposed add-on codes that would supplement payment for care of complex patients or extended visits?
- When selecting levels based on time for reporting add-on code 99XXX, how should practitioners document non face-to-face time? More generally, how should practitioners document these new add-on codes?
- When reporting GPC1X, how does a practitioner differentiate between using the add-on code or selecting a higher visit level?
- Could CMS further explain and clarify the projected use of GPC1X? For instance, how does CMS define “serious” in the code descriptor?

Maintaining separate payment rates for all E/M level visits

CMS proposal (84 Fed. Reg. 40673): CMS proposes to revise last year’s policy finalized for CY 2021, which would have applied a single, blended payment rate for levels 2 through 5 office visits for new and established patients, respectively. CMS now proposes to maintain separate payment rates for all E/M level visits for established patients and reduce the number of levels for new patients to four by deleting level 1 visits.

MGMA comment: MGMA supports the proposal to maintain separate payment rates for E/M level visits and appreciates CMS engaging with the physician community to address concerns about last year’s finalized rule to collapse the payment rates. The proposal to collapse and blend payment rates for levels 2 through 5 would have essentially treated all office visits the same, regardless of a patient’s condition or the complexity of the services provided. The unintended consequences of this proposal would have forced medical practices to reduce their Medicare patient volume or limit the medical issues addressed during one office visit due to lower reimbursement rates for more complex visits.

Moreover, in drafting the proposal to collapse payment rates, CMS assumed that other payers, including Medicaid and commercial plans, would follow Medicare’s direction and collapse the payment rates as well. However, although payers may be inclined to adopt lower reimbursement amounts, it is unlikely that all payers would adopt the documentation changes in their entirety due to the proposed guidelines not being clear or comprehensive enough. Collapsing payment rates for levels 2 through 5 would have unintended, catastrophic effects on physicians’ abilities to effectively treat Medicare beneficiaries. MGMA supports CMS’ current proposal to maintain separate payment rates for all E/M level visits.

Selection of appropriate E/M level based on MDM or time

CMS proposal (84 Fed. Reg. 40671): For levels 2 through 5 E/M visits, CMS proposes that the code level reported would be decided based on either the level of MDM or total time personally spent by the reporting practitioner on the day of the visit. Under this new proposed framework, history and exam would no longer be used to select the code level, unless medically necessary.

MGMA comment: MGMA supports CMS' proposal to allow physicians to select code levels based on MDM or time. MGMA members have noted that selecting code levels based on history or exam can prove time-consuming, burdensome, and at times, unnecessary. However, we agree with the agency that it is necessary to leave history and exam as an option when medically necessary.

With the new coding framework, MGMA encourages CMS to provide education surrounding the documentation requirements needed when utilizing MDM to select visit level. MGMA members are concerned that the lack of documentation guidance will result in increased audits and denial of payment.

E/M add-on code 99XXX

CMS proposal (84 Fed. Reg. 40673): CMS proposes to create an add-on code (CPT code 99XXX) to account for extended time on the date of the primary service when time is utilized to select code level. CPT code 99XXX would replace the prolonged services code (GPRO1) CMS previously planned to use for CY 2021.

MGMA comment: There is confusion regarding codes 99358 and 99359 (prolonged E/M services before and/or after patient care) and whether these can be reported in addition to or instead of the new 99XXX add-on code to describe extended time. Despite CMS' assertion that having one (99XXX) instead of multiple add-on codes (99358 and 99359) would be "administratively simpler and most consistent with [the] goal of documentation burden reduction," MGMA disagrees unless 99XXX would apply to time spent outside of the date of service timeframe.

CPT code 99XXX, as proposed, would account for extended time on the date of encounter, while CPT codes 99358 and 99359 describe time spent on dates before and/or after patient care. MGMA believes that time spent on patient care outside of the date of service should factor into physician payment and would closely align with the agency's mission of achieving value-based care. Additionally, the rate of physician burnout due to the increasing paperwork requirements and administrative burden is alarming and should signal to the agency that clinical time spent on patient care should be accounted for, regardless of whether it was on the date of service. According to a [study](#) published by the *Annals of Internal Medicine*, physician burnout is costing the U.S. health care system roughly \$4.6 billion a year and a leading cause of burnout is paperwork. Paying practitioners for the time spent on necessary patient care outside of the date of service framework directly addresses this pressing issue.

E/M add-on code GPC1X

CMS proposal (84 Fed. Reg. 40676): CMS proposes to create a single add-on code related to E/M services to describe visit complexity (HCPCS code GPC1X) starting in CY 2021. Through the current proposed rule, CMS proposes to simplify the add-on coding finalized in 2019 rulemaking by consolidating the two add-on codes into a single code that describes the work associated with visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition. Specifically, CMS proposes to revise the descriptor for code GPC1X and delete code GCG0X. The revised GPC1X would increase in value and apply to all office/outpatient E/M visit levels.

MGMA comment: MGMA agrees with CMS that "the revised office/outpatient E/M code set does not recognize that there are additional resource costs inherent in furnishing some kinds of office/outpatient visit." Further, we agree there is a need to account for the additional resources and costs associated with furnishing complex E/M visits, but we have reservations about aspects of the GPC1X add-on code and believe that refinements should be made such that this code accomplishes its intended purpose.

We support CMS' efforts to simplify the potential add-on codes, and further support recognition of visit complexity through "different per-visit resource costs based on the kinds of care the practitioner provides," rather than "based on billing practitioner's specialty." GPC0X, which CMS finalized for

2021 implementation but is now proposing to delete, described complexity associated with certain specialty visits and enumerated only select specialties. We support the approach outlined in the current proposal, which is more patient-centric, rather than specialty-driven.

While CMS' proposals around the complex E/M visit add-on code are an improvement over what was finalized last year, MGMA remains concerned this add-on code is not the best way to address the need to account for additional resources and costs associated with furnishing E/M visits for complex cases. As proposed, this code is too vague, which deters utilization. For example, CMS should provide further guidance around clinical situations that meet the definition of a "single, serious, or complex chronic condition," as well as documentation expectations. Lastly, CMS' assumptions regarding anticipated utilization are not clearly outlined. We request clarification around utilization assumptions, as well as additional information around billing guidance and documentation requirements for the complex E/M visit add-on code.

Care Management Services

Transitional Care Management (TCM) services

CMS proposal (84 Fed. Reg. 40549): Under current policy, TCM services cannot be billed concurrently with 57 codes during the 30-day period covered by TCM. Starting in CY 2020, CMS proposes to allow TCM billing with 14 of those codes previously prohibited from concurrent billing, such as prolonged services without direct patient contact and complex chronic care management services, as described in Table 17 of the proposed rule. Additionally, CMS proposes to increase payments by adopting the AMA RUC-recommended work RVUs of 2.36 for CPT code 99495 and 3.10 for CPT code 99296. The 2019 work RVUs for these services were 2.11 and 3.05, respectively.

MGMA comment: MGMA supports CMS' proposal to adopt the AMA RUC's recommendations to increase payment for the two TCM codes. While we appreciate efforts to encourage the appropriate billing of TCM services, we are concerned that making the guideline change around concurrent billing without CPT review could generate confusion for clinicians billing for these services. We urge the agency to work with the CPT editorial panel to review TCM guidelines to determine the appropriateness of concurrent billing proposals.

CCM services

CMS proposal (84 Fed. Reg. 40550): CMS proposes to replace the single existing CPT code describing non-complex CCM (99490) with two G-codes with time-based increments of clinical staff time. The first G-code (GCCC1) would cover the initial 20 minutes of clinical staff time and the second code (GCCC2) would describe each additional 20 minutes thereafter. This change and creation of a new non-complex CCM add-on code is intended to recognize additional time spent on non-complex CCM.

CMS also proposes to replace existing CPT codes for complex CCM with new G-codes that remove certain billing requirements and clarify what must be included in the "typical care plan" required for complex CCM. CMS proposes to replace 99487 with GCCC3 and 99489 with GCCC4 and remove the service component of the substantial care plan revision element.

MGMA comment: We agree with the agency that CCM coding should be refined to alleviate burden and improve payment accuracy, however we do not believe that proposed changes to administrative billing requirements would resolve fundamental barriers to receiving reimbursement for these codes. Moreover, we do not believe that the benefit of implementing temporary G-codes outweigh the disruption that would be caused by transitioning from CPT to G-codes. Instead of moving forward with replacing all of the current CCM coding, we encourage CMS to work with the CPT editorial panel on changes to CCM codes. Use of CPT codes creates consistency across the industry and reduces

inadvertent billing inaccuracies, and continually switching back and forth to G-codes generates confusion for clinicians and their coders.

While many clinicians may be performing care management services, they are not being reimbursed for this important work due to billing restrictions. We encourage CMS to address the real barriers to CCM reimbursement, which often stem from the requirement to collect a patient cost-sharing amount. Patients without supplemental insurance that covers CCM cost-sharing requirements are not accustomed to receiving bills for services and may not consent to receiving monthly CCM for this reason. One academic medical center in Alabama informed us that “almost universally, when we try to obtain consent from the patient, they decline based on the copay.” Further, the cost for the practice to transmit a patient bill often exceeds the patient cost-sharing portion.

While CMS has indicated that it lacks the authority to waive beneficiary co-insurance, MGMA recommends CMS consider using its demonstration authority to test care management services without the cost-sharing element, evaluate patient satisfaction and access, assess potential savings to the program, and if successful, bring the data to Congress for a legislative remedy to allow for expansion of the model that removes any patient cost-sharing for CCM or similar services. A Nov. 2018 [report](#) commissioned by CMS’ Innovation Center indicated that utilizing CCM services reduced costs by \$74 per beneficiary per month relative to a comparison group over the 18-month period studied. The report found “clear support that CCM is having a positive effect on lowering the growth in Medicare expenditures on those that received CCM services” and that beneficiaries in the CCM program had lower hospital, emergency department, and nursing home costs.¹ This data tends to show that CCM services have the potential to decrease costs for both the program and beneficiaries, and can serve as preventative measure to exacerbation of existing or onset of additional conditions.

An additional barrier group practices report to implementing CCM and receiving reimbursement is unclear guidelines around what conditions qualify a patient to receive CCM. While we appreciate that CMS has not been overly prescriptive in enumerating an exhaustive list of chronic conditions that meet billing guidelines, we request additional clarification from CMS around the types of conditions it envisions as meeting the necessary criteria to qualify as a “complex chronic condition.” For example, MGMA members have inquired as to whether “chronic pain” would qualify as one of the two required chronic conditions for CCM billing.

Principal Care Management (PCM) services

CMS proposal (84 Fed. Reg. 40553): CMS proposes to introduce a newly covered code for PCM services, which would describe care management for patients with a single complex chronic condition. The full scope of service requirements for CCM services would apply to PCM services. HCPCS code GPPP1 would describe comprehensive care management services for a single high-risk disease with at least 30 minutes of physician or qualified healthcare practitioner time per month. HCPCS code GPPP2 would describe at least 30 minutes of clinical staff time spent on comprehensive management of a single condition.

MGMA comment: Similar to our comments around CMS’ proposed revisions for CCM codes, we appreciate recognition by the agency of the work that clinicians and medical staff perform outside of the traditional office visit. However, we express the same concerns for the PCM code as we do for CCM regarding patient cost-sharing obligations and consent requirements as barriers to implementation. If the PCM codes are finalized, we request clarification around the types of conditions that would qualify a patient for PCM services. For example, a gastroenterology practice asked MGMA if irritable bowel disease would be a qualifying chronic condition.

¹ Evaluation of the Diffusion and Impact of the CCM Services: Final Report (Nov. 2017).

Coinsurance for Colorectal Cancer Screening

CMS proposal (84 Fed. Reg. 403556): Colorectal cancer screening tests are “preventative services” under the Affordable Care Act, which are paid 100% by Medicare without beneficiary cost-sharing. CMS does not consider flexible sigmoidoscopies or colonoscopies to be preventative “screening tests” if, during the course of screening, a clinician determines a polyp must be removed. As a result, CMS interprets these tests to be diagnostic in nature and that beneficiaries should be responsible for coinsurance amounts (20% or 25% depending on the care setting). CMS seeks comment on whether to require clinicians furnishing colorectal cancer screenings to notify the patient in advance that the screening procedure could become a diagnostic service and that coinsurance may apply.

MGMA comment: MGMA does not agree that the solution to this problem is to add more administrative burden to physician practices and increased costs for beneficiaries. Rather than implement a consent or notification requirement, MGMA encourages CMS to include polypectomies that result from a colonoscopy screening as a colorectal cancer benefit. We encourage CMS not to move forward with a notice requirement regarding potential cost-sharing obligations.

Adding Services to the List of Medicare Telehealth Services

CMS proposal (84 Fed. Reg. 40518): CMS proposes to add the following services that address opioid use disorder (OUD) to the list of approved telehealth services starting in CY 2020:

- HCPCS code GYYY1: Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month;
- HCPCS code GYYY2: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in subsequent calendar month; and
- HCPCS code GYYY3: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (List separately in addition to code for primary procedure).

MGMA comment: MGMA supports the proposal to add codes to the list of approved telehealth services because telehealth services amongst Medicare beneficiaries are heavily underutilized. In 2016, only 0.25% of more than 35 million Medicare fee-for-service (FFS) beneficiaries utilized telehealth services.² We recognize that CMS is barred by statute from eliminating geographic and originating site restrictions which impede telehealth expansion, however the agency has the authority to undertake telehealth demonstrations that would waive these restrictions for a select number of services to evaluate whether or not expansion is necessary. Therefore, MGMA strongly encourages CMS to issue a request (or requests) for proposals for demonstrations to evaluate telehealth services Medicare currently covers by waiving statutory geographic and originating site restrictions. In issuing a request for proposals, we hope it will lead to an increase in telehealth utilization for Medicare recipients that could significantly benefit from these services.

Modernizing Physician Payment through Communication Technology-based Services

Consent requirement

CMS proposal (84 Fed. Reg. 40556): In the CY 2019 PFS final rule (83 Fed. Reg. 59482), CMS finalized new separate payments for communication technology-based services, including a virtual check-in and a remote evaluation of pre-recorded patient information. In their 2020 proposal, CMS

² CMS, Information on Medicare Telehealth Report, Nov. 15, 2018

acknowledges the burden associated with requiring advance consent from beneficiaries for these services and therefore seeks comment on the appropriate interval of time or number of services for which consent could be obtained as well as potential program integrity concerns associated with allowing advance consent.

MGMA comment: MGMA is supportive of communication technology-based services, however we agree that requiring beneficiary consent for each service is burdensome. We believe that for the Medicare beneficiaries who are currently utilizing these services, obtaining consent once for every ‘X’ number of services would ease the burden on both the practitioner and the patient. MGMA recommends that CMS engage with the physician community to assess at what frequency obtaining consent should occur. We believe that initial consent is necessary to ensure patients are aware of any cost-sharing obligations that may incur as a result of the communication technology-based services but believe that it is unnecessary to obtain consent for each visit that follows.

Another significant impediment to the adoption of these services is the cost-sharing component associated with obtaining consent from beneficiaries. More specifically, beneficiaries are unaccustomed to paying for services that are not face-to-face, especially if they have not been seen by the practitioner before. Therefore, we encourage CMS to explore other avenues within its statutory authority or seek expanded authority to eliminate the patient cost-sharing element of these communication technology-based services.

Finally, for medical group practices to begin offering new services, such as communication technology-based services, it often requires time to design internal processes as well as to train and educate staff. MGMA encourages CMS to continue to work collaboratively with the physician community to produce further education and resources to ensure these newer services are implemented for beneficiaries that could significantly benefit from them.

Advisory Opinions on the Application of the Physician Self-referral (Stark) Law

Revisions to CMS advisory opinion process

CMS proposal (84 Fed. Reg. 40727): CMS proposes several modifications to the process for requesting an advisory opinion on the Stark Law. CMS proposes to ease the restriction at 42 CFR 411.370(e)(2) that prohibits the acceptance of an advisory opinion request or issuance of an opinion if the agency is aware of pending or past investigations involving a course of action that is substantially the same; instead CMS would allow greater discretion to determine, in consultation with the Office of Inspector General (OIG) and Department of Justice (DOJ), as to whether acceptance of the advisory opinion request is appropriate.

Although CMS is not currently proposing to expand the process to include hypothetical fact patterns, the agency solicits comments on whether it should do so in the future.

MGMA comment: MGMA supports any effort to simplify the Stark Law and to add clarity to its confusing terminology and broad application; improvements upon the advisory opinion process could help mitigate burden created by the Stark Law, at least at the margins.

We support expanding the scope of the advisory opinion process and encourage CMS to adopt a policy to consider requests that involve hypothetical fact patterns. The Stark Law’s confusing terminology, broad application, and potentially ruinous consequences significantly restrict a practice’s ability to pursue innovative arrangements that may be innocuous and beneficial to clinical care yet at the same time may invoke scrutiny under the Stark Law. The ability to request and receive an advisory opinion around a potential arrangement is exactly the type of inquiry that would be particularly useful for group practices that want to enter into an innovative arrangement but need clarification around the Stark Law implications.

Application of the Stark Law is incredibly fact-dependent, and whether an arrangement violates or invokes the law turns on the specific facts of an arrangement. Therefore, while there may be an investigation—or an opinion—on one course of action, slight modification of the facts may produce an entirely different outcome. As an example, CMS opined in May 2008 that the provision of software to communicate test results by a hospital to medical staff physicians in private offices did not constitute a compensation relationship under the Stark Law.³ The opinion emphasized the limited scope of the technology, which begs the question as to whether more comprehensive technology provided by a hospital to a physician practice would constitute a compensation relationship. What about software that transmits Admit, Discharge, and Transfer (ADT) feeds? TCM workflow tools? Data analytics around emergency department admissions during office hours? Should CMS decide to accept advisory opinion requests based on hypothetical questions, group practices could benefit from having CMS weigh-in on a potential arrangement that may be slightly different than a separate arrangement that CMS has either investigated or opined on.

Fees for the cost of advisory opinions

CMS proposal (84 Fed. Reg. 40729): As set forth in 42 CFR 411.375, requestors of an advisory opinion on the Stark Law are responsible for an initial fee of \$250, plus any additional costs incurred that exceed the initial payment amount. Requestors may designate an amount that CMS must not exceed to prevent incurring excessive costs.

As part of its revisions to the Stark Law advisory opinion process, CMS proposes a new fee structure. The agency would adopt an hourly fee of \$220, with an option for expedited review within 30 days of the request for an increased hourly rate of \$440 an hour. The agency solicits comment on whether to implement a cap on the amount of fees charged for an advisory opinion.

MGMA comment: MGMA requests that CMS release data around the current costs associated with requesting a Stark Law advisory opinion so that we can more accurately consider the implications of this proposed change in fee structure. Group practices may have limited resources available to expend on costly fees, yet group practices are exactly the type of entities that could benefit from receiving an advisory opinion from CMS. MGMA is not aware of current data around how fees add up under the current process given the ambiguity of the terminology of “any additional costs,” and therefore cannot make an informed opinion as to whether the proposed change is reasonable or would result in excessive fees. Notwithstanding the lack of clarity around fee accrual, we would support implementation of a cap on fees, after which CMS would continue consideration of the fact pattern subject to the advisory opinion without charge. Should CMS move to an hourly-based fee schedule for Stark Law advisory opinions, MGMA encourages the agency to consider whether it could provide an estimate to potential requestors regarding anticipated costs before the requestor has committed to incurring them.

Reliance on advisory opinions

CMS proposal (84 Fed. Reg. 40729): CMS proposes to clarify that all parties to an arrangement subject to a favorable advisory opinion would be permitted to rely on the opinion, regardless of whether they were a requestor of the opinion. Therefore, if CMS determines that an arrangement does not violate the Stark Law, the determination would apply equally to any individuals and entities that are parties to the specific arrangement. Currently, CMS precludes reliance on a favorable advisory opinion by third parties. CMS proposes that, in addition to “individuals or entities that are parties to the specific arrangement,” “individuals or entities that are parties to an arrangement that CMS determines is indistinguishable in all material aspects from an arrangement that was the subject of the advisory opinion,” may rely on an advisory opinion.

³ CMS AO-2008-01.

Further, CMS proposes to amend 42 CFR 411.387(c) to clarify that the general public may reasonably rely on an advisory opinion as “non-binding guidance” on interpretation of the Stark Law.

MGMA comment: MGMA supports CMS’ proposal to expand the types of entities that may rely on the outcome of an advisory opinion, as well as the proposal to permit the general public to rely on advisory opinions as interpretive non-binding guidance. For the reasons set forth above, we believe that any effort to clarify and provide additional, formal guidance around Stark Law interpretation could be beneficial to group practices.

We appreciate the agency’s consideration of MGMA’s [responses](#) to the 2018 RFI on how to improve the Stark Law. As indicated in those responses, we urged the agency to issue a broad Stark Law exception for value-based arrangements that meet certain conditions. We look forward to the issuance of the proposed rule reforming the Stark Law that is currently pending with the Office for Management and Budget and believe, if broad enough, that rule could offer additional opportunities for group practices to participate in value-based arrangements. Coupled with a robust advisory opinion process, this could benefit group practices that seek additional clarification or guidance around the types of arrangements that satisfy this any new exception or clarified policies.

Lastly, to truly encourage innovative arrangements, we offer the following suggestion regarding CMS’ Stark Law advisory opinion process. Currently, CMS will only opine on whether an arrangement meets a Stark Law exception. We suggest that the agency explore whether it has legislative authority to issue opinions that offer protection for arrangements, even if they may not fit squarely within an exception. Similar to the process used for OIG advisory opinions on Anti-kickback Statute inquiries, CMS could protect arrangements that present no significant risk of harm.

Medicaid Promoting Interoperability Category

eCQMs

CMS proposal (84 Fed. Reg. 40702): “Medicaid Promoting Interoperability Program for [eligible professionals (EPs)] received positive comments that indicated that alignment between these two programs would help reduce health care provider reporting burden (83 FR 59702). These comments thus suggest that aligning the eCQM lists might encourage EP participation in the Medicaid Promoting Interoperability Program by giving Medicaid EPs that are also MIPS eligible clinicians the ability to report the same eCQMs as they report for MIPS. Not aligning the eCQM lists could lead to increased burden, because EPs might have to report on different eCQMs for the Medicaid Promoting Interoperability Program if they opt to report on newly added eCQMs for MIPS.”

MGMA comment: MGMA strongly supports the agency’s effort to align the eCQMs between the Medicaid promoting interoperability program and the eCQM reporting required under the MIPS program. Member groups can segment their clinicians with some participating in the Medicaid promoting interoperability program and others participating in the MIPS program. This alignment of eCQMs permits the practice to develop a much simpler workflow process to report these quality measures and decreases costs associated with use of technology to capture and report these measures.

CMS proposal (84 Fed. Reg. 40702): “For 2020, we propose to again require (as we did for 2019) that Medicaid EPs report on any 6 eCQMs that are relevant to their scope of practice, regardless of whether they report via attestation or electronically.”

MGMA comment: We agree with the agency’s proposal to again require that Medicaid EPs report on any 6 eCQMs that are relevant to their scope of practice. One of the concerns of the provider community regarding the various CMS quality reporting programs, however, has been that many medical specialties lack sufficient quality measures and are forced to report measures that are out of scope for their specialty. We urge the agency to continue working with the medical specialty

societies to ensure that there are sufficient quality measures to select from and report.

Reporting period

CMS proposal (84 Fed. Reg. 40703): “We also propose that the 2020 eCQM reporting period for Medicaid EPs who have demonstrated meaningful use in a prior year be a minimum of any continuous 274-day period within CY 2020. This 274-day eCQM reporting period corresponds to the 9-month period from January 1, 2020 to September 30, 2020.”

MGMA comment: With the Medicaid promoting interoperability program slated to end in 2021, we understand why the agency would seek to shorten the reporting period from a full year to a 274-day period. The agency has indicated this shortened period would give states additional time to calculate scores and promptly issue incentive payments. We recommend shortening this reporting period even further, to any 90 consecutive days between Jan. 1, 2020 and Oct. 31, 2020. While continuing to provide CMS with more than sufficient data, it would also significantly reduce the administrative burden associated with reporting the data.

HIPAA Security Risk Analysis

CMS proposal (84 Fed. Reg. 40704): “Therefore, we are proposing to allow Medicaid EPs to conduct a security risk analysis at any time during CY 2021, even if the EP conducts the analysis after the EP attests to meaningful use of CEHRT to the state. A Medicaid EP who has not completed a security risk analysis for CY 2021 by the time he or she attests to meaningful use of CEHRT for CY 2021 would be required to attest that he or she will complete the required analysis by December 31, 2021.

MGMA comment: While we oppose continuing to require a security risk analysis as part of the Medicaid promoting interoperability program, as it has been a requirement for providers who are HIPAA covered entities since 2005, should it be required as part of the 2020 program we support the proposed changes. It is appropriate to allow a Medicaid EP until the end of the calendar year to perform this task and attest to its completion as they may be on a yearly schedule that falls outside the proposed shortened reporting period.

Medicare Shared Savings Program (MSSP)

Quality measurement

CMS proposal (84 Fed. Reg. 40705): CMS proposes to remove one MSSP quality measure (ACO 14 – Preventive Care and Screening Influenza Vaccination) and add another (ACO 47 – Adult Immunization Status). CMS also seeks comment on whether and how to align the MSSP quality scoring approach with the MIPS quality category and discusses an approach that would evaluate ACOs using the MIPS quality reporting methodology, including the administrative-claims based measure.

MGMA comment: Given the recent significant changes to the structure of the MSSP through the Pathways to Success rule, including the accelerated timeline to move to risk-bearing tracks, MGMA believes this is not the time to implement further uncertainty and higher quality scoring standards for ACOs by introducing the MIPS scoring system for MSSP quality measurement. While we appreciate efforts to align quality reporting programs, we do not believe that applying the MIPS quality performance score (converted to a percentage of points earned out of total points available) for purposes of MSSP ACO quality assessment is the right approach. As MSSP ACOs will either be designated as an Advanced APM or working toward achieving this status depending upon payment track, we do not feel application of MIPS scoring policies is necessarily appropriate. Instead, we urge CMS to work with stakeholders to make refinements to the current quality measure set for ACOs. We support CMS testing the use of a limited number of measures with low reporting burden. We recommend CMS implement voluntary testing and welcome the opportunity to help the agency

implement this strategy to identify the next generation of quality measurement within the existing ACO program structure and methodology.

Additionally, we have concerns with the proposal to add ACO-47 to the quality measure set in 2020 and instead urge CMS to maintain ACO-14 until further testing can be undertaken to determine whether it is appropriate to measure ACO-47 at the physician or ACO level.

Quality Payment Program

MIPS Value Pathways

CMS proposal (84 Fed. Reg. 40730): In an effort to improve the clinical relevance of MIPS and reduce reporting burden, CMS proposes a new concept called “MIPS Value Pathways” (MVPs) starting in CY 2021. In addition to proposing this new concept, CMS includes an RFI around key details of the Value Pathways concept. CMS provides a high-level overview of the MVP concept, describing an episode-based framework that would organize reporting requirements for each MIPS category around either a specific specialty (i.e., ophthalmology), clinical condition (i.e., diabetes), or a priority area (i.e., preventative health). The agency envisions these Pathways would eventually replace the current MIPS reporting structure in that clinicians would either choose or be assigned a Pathway based on clinical factors. Each Pathway may feature a smaller number of quality, cost, and/or improvement activity measures, therefore reducing reporting burden while still offering full reporting credit. CMS envisions that the Pathways concept would more closely align MIPS with APMs and anticipates that MVP participants would receive more robust and timely feedback.

MGMA comment: MGMA appreciates that CMS is taking steps to simplify and streamline the MIPS program, and we are encouraged by the high-level framework CMS sets forth in the 2020 PFS proposed rule. The Association has long urged the agency to pursue changes to MIPS in order to make the program more clinically relevant, less burdensome, and more aligned with Congress’ intent in MACRA to move group practices into value-based arrangements such as APMs. We continue to hear from our members that the current program is too costly and requires reporting for reporting’s sake, diverting time from patient care. While we are supportive of this effort, we do have reservations about certain aspects of the MVP framework outlined in the RFI:

- The return to and focus on population-based administrative claims measures;
- Any assignment by CMS or mandate to report on one specific MVP;
- Retention of the full promoting interoperability category requirements;
- Continuation of a siloed approach to the promoting interoperability and improvement activity categories;
- Employing an implementation timeline that is too aggressive and does not allow sufficient time for development of meaningful measures, accurate evaluation, and operational considerations; and
- Potential to increase costs associated with MIPS reporting and elimination of a low-cost reporting option.

Additionally, given the short turn-around for comments on the 2020 PFS proposed rule and the breadth of changes and requests outlined in the MVP RFI, we are still gathering feedback from our members on the MVP concept and how it would affect group practices. As such, we encourage the agency to continue soliciting feedback from stakeholder groups beyond the submission deadline for RFI responses.

CMS proposal (84 Fed. Reg. 40732): CMS describes its vision for MVPs that includes the following framework principles:

- Using a limited set of measures and activities that are meaningful to clinicians, which will reduce or eliminate clinician burden related to selection of measures and activities, simplify

- scoring, and lead to sufficient comparative data;
- Including measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers in evaluating performance and making choices about their care;
- Including measures that encourage performance in high priority areas;
- Reducing barriers to APM participation.

MGMA comment: We support the approach to use a limited number of measures in each Pathway in order to allow clinicians to truly select and report the most meaningful measures to their patients and practice. Rather than focus on requiring a set number of measures—i.e., six quality measures—and instead focus on meaningful measures that are clinically relevant to a specialty, condition, or public health priority, MVPs have the opportunity to make MIPS a more meaningful quality initiative, rather than simply a reporting requirement. This approach could 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 clinical decision support (CDS).

Within the first principle outlined, we do not agree with completely eliminating “burden related to selection” of measures if it means that clinicians would only be permitted to report on one MVP assigned to them by CMS, for the reasons set forth in our section on MVP assignment. We submit that the burden associated with MIPS is more accurately described in terms of the quantity of measures must be reported, not the quantity of measures available for selection.

While we support an emphasis on high priority clinical areas, we encourage CMS not to implement an overly prescriptive policy around MVPs that would require each MVP to include certain types of measures, such as a set amount of outcomes-based measures.

Regarding the principle to reduce barriers to APM participation, we support an approach to MVPs that would strike a middle ground between the two current QPP options, where practices take accountability for outcomes and costs for particular episodes and improving care workflows and infrastructure, without forcing them to immediately redesign every aspect of care delivery or taking on significant downside financial risk. CMS should also consider MVP proposals in future rulemaking that include more flexibility to improve value for the patient population. For example, the specialty society or other stakeholder group proposing an MVP could propose certain payment changes to support improvements needed to care for a condition, such as being able to bill for CCM for patients with the condition even if they do not meet each element required to bill for the service, or paying for collaborative care to help support team-based approaches to managing patient care. CMS could work with the Innovation Center to leverage its waiver authority for certain MVPs to implement payment or any other waiver that may facilitate greater success in MVPs. Although MVP clinicians would not be subject to the two-sided risk requirements of Advanced APMs, the MIPS measures of cost and quality for the episode and MIPS payment adjustments will serve to hold them accountable in a similar manner to APM participants.

Timeline

CMS proposal (84 Fed. Reg. 40732): CMS proposes to begin implementation of the MVP concept in performance year 2021.

MGMA comment: While MGMA is eager to see the MVP concept take off, we urge CMS against an implementation timeline that is too aggressive and rolls the program out before development an appropriate framework. For example, part of the complexity around the MIPS program is constant year-over-year changes to measure reporting requirements, category weights, scoring policies, and other key details. While we understand that some program changes are necessary to improve on inefficiencies or problem areas, we encourage CMS to take a cautious and thoughtful approach rather

than quickly roll out the MVP framework for the sake of implementing it as soon as possible. Given that CMS does not finalize policies for the next reporting year until around November, practices only have two months to digest new information and make necessary operational changes. Moreover, this timeframe does not allow sufficient time for vendors to implement potentially new measures and have them ready to report by January 1, since quality measures must be reported for a full year. In gathering feedback from MGMA members around the MVP framework, we heard concerns that a timeline that begins MVPs too soon will limit choice in vendors; assuming that not all vendors will be able to implement significant changes under such a tight turnaround, practices reporting MVPs will be limited to selecting vendors that have measures ready to go.

To ease the transition process, MGMA suggests that the agency consider piloting the MVP concept. For example, CMS could pilot the MVP concept in a similar fashion as the improvement activities study (albeit proposed for retirement in the 2020 performance year), where practices can receive reporting credit for their efforts to assist CMS and offer their input and experiences through listening sessions and regular engagement with CMS. We expect there are few MVPs finalized during the initial years of implementation, and therefore piloting the concept could offer the opportunity to improve upon MVP design.

Assignment

CMS request: If technically feasible, CMS would like to establish a methodology whereby it identifies and assigns in advance relevant MVP(s) and require reporting on that MVP. To this end, CMS solicits feedback on how to determine the most relevant MVPs for clinicians and groups; how to identify the most appropriate MVP (such as through specialty in PECOS or on claims); what tools would be helpful for clinicians to understand what MVPs may be applicable.

MGMA comment: MGMA does not support assignment of MVPs if it means a clinician or group is *required* to report on a CMS-selected measure set. We do not support mandatory assignment of MVPs under any circumstance when it eliminates choice completely. Instead, MVPs should be a voluntary QPP participation option; clinicians and group practices should continue to have the option to participate in traditional MIPS and should have the option to experiment with reporting different MVPs, particularly as they are rolled out. Furthermore, where there may be more than one MVP available to a group practice based on specialty mix or patient population, we encourage CMS to allow the group practice or its individual clinicians to experiment with multiple MVPs and receive MIPS credit even if one MVP is not reported for an entire year. A clinician may want to “test” an MVP and through that testing process may determine it is not clinically relevant or the best fit. The clinician should not be bound to continue reporting that MVP for reporting’s sake and should instead be permitted to “switch” to another MVP to test its applicability without fear of failing to meet full-year reporting requirements that apply to select MIPS categories.

CMS suggests that MVPs could be created around not only specialty designation but also patient clinical condition or public health priority. We support creation of MVPs around all of these areas. Assigning MVPs based solely on specialty would frustrate development of MVPs around these other priority areas. Further, use of specialty designation as the sole method to determine relevant MVPs is an overly simplified approach that does not consider unique practice or clinician characteristics, such as geographic variation, patient population, practice size, clinician type, and so forth.

Lastly, assignment of MVP based on specialty designation through Medicare raises significant operational concerns. For example, with PECOS specialty designations, the agency would not be able to gather information on specialty designation from non-physician practitioners (NPPs) as they will not have a Medicare specialty designation.

Rather than require a particular MVP, MGMA urges CMS to utilize an approach where the agency offers a recommendation to clinicians based on claims data from the individual clinician and/or group

practice. In order to provide clinicians with reliable and accurate information regarding potentially relevant MVPs, MGMA recommends that CMS provide group practices and clinicians with specific data and information to assist in the voluntary selection of clinically relevant MVPs. CMS should have sufficient claims data to provide this type of information to clinicians and to offer *recommendations* on potential MVP selection. The agency could accomplish this by using previous year National Provider Identifier (NPI)-level claims data and including the recommendation in the clinician or group's QPP account. We encourage the agency to establish a process whereby CMS recommends an MVP and then permits the clinician or group practice to "opt-in" to reporting that MVP for MIPS credit. We also encourage CMS to consider whether to assign bonus points or create other incentives that encourage clinicians to "opt-in" to reporting the CMS-recommended MVP. The agency could then gather data on performance for that particular MVP, whether based around specialty, patient condition, or public health priority, to use to improve MVP measures and activities in the future.

Organization of MVPs

CMS request: CMS requests information on: how to organize MVPs, such as around specialties and areas of practice; how to ensure the right number of MVPs are included in a particular Pathway; whether to limit the number of MVPs; and whether each specialty should have one MVP.

MGMA comment: As stated above, MGMA supports development of MVPs around clinical specialty, patient condition, *and* public health priority. Where there is sufficient need to incentivize reporting around a public health priority, such as opioid use, MGMA encourages CMS to consider offering a bonus or other incentive to report on such MVP.

While the goal of allowing participants to receive credit across categories simplifies and increases the relevancy of each category, the particular measures and/or activities that will be included in each Pathway will need to be clearly outlined. There must be an openness to accept and implement emerging measures that would demonstrate quality based on new evidence and data. We encourage the agency to regularly engage with specialty societies in the development of MVP measures and activities.

We appreciate the approach outlined by CMS to connect the quality and cost performance categories. We encourage the agency to take additional steps to simplify and refine this approach such that it allows greater opportunity for cross-category credit for activities and measures that overlap performance categories. We are concerned, however, that CMS' approach would continue to silo the promoting interoperability category and would require that MVP reporters fulfill all promoting interoperability requirements. MGMA does not support this and urges CMS to provide greater alignment of promoting interoperability measures, as well as improvement activities, with the core foundation of the MVP.

Specifically, we do not support retention of the entire promoting interoperability category as a foundational element of all MVPs. Existing promoting interoperability measures are burdensome and often not clinically relevant to all practices, which is counter to the very intent behind the creation of MVPs. For example, as CMS has acknowledged through implementation of the promoting interoperability re-weighting policies, this category is not relevant to all specialties or clinicians, such as non-patient facing clinicians. While we support the re-weighting of promoting interoperability for these clinicians that participate in MIPS, as CMS is developing new policy around MVPs, the agency has the opportunity to consider the clinical relevance of promoting interoperability measures within each Pathway at the outset of MVP creation. We encourage the agency to consider scenarios that merit exceptions to the promoting interoperability category as it exists now, as well as measure-level exclusions, while it is considering initial MVP creation. For example, rather than mandate that all MVPs include all promoting interoperability measures, CMS should consider which measures or objectives would not apply to a given specialty or practice based on site of service or clinical practice

and then exclude those measures or objectives in the initial MVP.

As another example of how all promoting interoperability measures/objectives may not apply to all group practices, the public health reporting objective has presented challenges for many members in certain geographical areas and in certain clinical specialties. MGMA frequently hears from members that there are no clinically relevant registries within their jurisdiction, which makes reporting this objective impossible for them.

While CMS offers exceptions to the public health objective, MGMA has heard from members that it can take hours to research available registries in their jurisdiction before deciding that the exception applies; this research may entail back and forth communications with relevant state public health departments, inquiries to specialty societies, and so forth. One group practice reported that they are required to report through a state health information exchange as a condition of participation in the Medicaid program, however the state informed the practice that such reporting would *not* qualify for MIPS reporting. This determination took multiple communications across multiple parties, resulting in frustration and administrative burden, and ultimately no opportunity for MIPS credit. MGMA members also reported confusion as to whether they were required to find an exclusion to each registry measure within the public health objective, or whether they were permitted to identify and document only two exclusions to account for the two required measures. It took months after the start of the performance period for CMS to release sub-regulatory guidance that clarified only two exclusions were necessary to fulfill objective requirements.

Therefore, rather than require all MVP participants report on the entirety of the promoting interoperability category or even undertake consideration of which measures could apply to which specialties or MVPs, MGMA recommends that CMS consider alternative policies for promoting interoperability. The agency should explore if use of digital tools or other technological pursuits would be sufficient to meet promoting interoperability requirements. For example, in an MVP around diabetes care, CMS could offer promoting interoperability credit for remote monitoring of physiological data of A1c levels. For a public health MVP around opioid abuse prevention, query of PDMP and other monitoring activities should meet promoting interoperability requirements. Alternatively, CMS should award full promoting interoperability credit if a certain percentage of group practice clinicians (or an individual clinician if reporting at the NPI level) attests to using CEHRT. This policy would align with requirements for models to qualify for an APM, which is consistent with CMS' intent in the MVP program to create a more viable pathway for MIPS participants to join an APM. This would also apply an across-the-board scoring policy for promoting interoperability, which would add stability to the MVP framework.

For the improvement activities category, CMS should use a more simplified approach than what is outlined in the MVP framework. Clinicians or group practices in MVPs should receive full improvement activity credit for attesting to one improvement activity identified by the MVP creator/steward. MVPs could include one activity (or one activity with an alternative if warranted) that corresponds with the Pathway's goals, and that activity should count for full improvement activity credit. Rather than the current approach to this category that utilizes high- and medium-weighted activities and contributes to overall program complexity, CMS should allow reporting on one improvement activity per MVP, regardless of weight, and count it as full category credit.

Selection of measures and activities and incentivizing QCDR reporting

CMS request: Whether to require a specific collection type for MVP data in an effort to create comparable data set. Should QCDR measures be integrated into MVPs along with MIPS measures, or should they be limited to specific MBPs consisting of only QCDR measures? How should the agency continue to encourage QCDR use.

MGMA comment: MGMA does not support offering an MVP through only one collection type, such as QCDR, as this approach risks disadvantaging practices that may not have the resources or financial capital to invest in the selected reporting mechanism. We regularly hear from MGMA members that while they may be interested in reporting through a registry or QCDR, they simply do not have the financial capacity to do so. Requiring that these practices report MVPs through a registry that costs money is counter to the underlying intent of MVPs to reduce burden for physician group practices.

CMS should allow clinicians and groups in MVPs the flexibility to report across multiple mechanisms, as the agency allows for MIPS reporters. Moreover, to support group practices, CMS must consider the expense of reporting MIPS data, whether through MVPs or otherwise, and continue to offer options that permit free or inexpensive reporting.

Either MIPS or QCDR measures should be available for an MVP. The MVP steward or developer should determine the appropriate measures for the MVP. While we would support a policy where CMS encourages electronic reporting via QCDR, we believe clinicians should also be permitted to report measures via any traditional MIPS reporting mechanism.

Stakeholder feedback

CMS request: How to involve the stakeholder community in MVP development, what type of outreach would be effective in gathering the voice of the patient, and whether to institute a call for MVPs that aligns with the policy developed for the call for measures.

MGMA comment: In order to develop an MVP program that is truly clinically relevant and reduces burden, CMS must engage with the physician community regularly throughout the development process. In addition to the current RFI, MGMA encourages CMS to hold listening sessions throughout the next year such that the agency can consider this feedback before proposing policies for 2021. We believe that regular dialogue, in addition to consideration of RFI comments from MGMA and other stakeholder groups, is critical as direct communication offers the opportunity to raise questions and discuss policy priorities and implementation details in a more interactive and meaningful format.

Small and rural practice participation

CMS request: How to structure MVPs to provide flexibility for small and rural practices to reduce reporting burden; should we have alternative measures and submission requirements for small practices, such as reporting on fewer measures; what types of technical assistance would be helpful.

MGMA comment: As we have articulated previously, CMS must continue to offer an inexpensive reporting option for group practices that do not have sufficient working capital to invest in expensive vendors or that do not have the ability to overhaul their reporting strategy to comport with MVP requirements. Given the goals of the MVP program to alleviate reporting burden and create an easier glidepath to APM participation, we do not want to see MVPs have the unintended consequence of leaving small practices behind and stuck in MIPS.

CMS should also offer technical support for small and rural practices as a component of any transition into MVPs.

Multi-specialty practice participation

CMS request: Can the MVP approach be used as an approach to sub-group reporting; should a group be able to identify which clinicians will report which MVP.

MGMA comment: MGMA has concerns about policies that carve up group practices solely for the sake of MIPS reporting and that partitioning practices into sub-groups undermines their ability to incentivize quality improvement behaviors among all staff. As we have expressed in the past, we also have concerns that applying MIPS payment adjustments to sub-groups would create a chaotic scenario

for practice administrators and raises questions about whether CMS would create a new MIPS identifier, which we do not support.

While we have historically been against sub-group reporting, we are still re-evaluating this position in the context of MVPs. To begin, we gathered feedback from our members regarding their views on sub-group reporting, and most of them did not support this concept. Feedback indicated that, under current MIPS policies, a sub-group reporting option would generally increase burden and invite more opportunity for error and administrative expense. However, we did receive some support for sub-group reporting in the quality category of MIPS, which was coupled with cautious optimism that this could potentially increase the clinical relevance of quality measures for specialists within a larger practice if implemented correctly. Feedback from MGMA members, which conveys varying positions, is summarized below.

- Breaking out sub-groups of certain specialists and requiring them to attest to “primary-care focused processes and measures that are inherent to MIPS would be detrimental to specialty group reporting.” For example, creating a separate sub-group of specialists that do not transfer or transition patients frequently would frustrate their ability to meet promoting interoperability requirements. In full group-level reporting, clinicians may be able to rely on the work by their primary-care based colleagues that perform these functions as part of their clinical practice. If sub-group reporting for the promoting interoperability category were implemented, sub-groups of specialists would be required to study each measure and exclusion to determine their reporting strategy. This approach defeats efforts to reduce burden and create a more coordinated approach to patient care.
- A dermatology sub-group of a larger practice reported that the MIPS quality measures selected by the larger group do not apply to them, and cannot even be recorded in their EMR, which is specialty-specific. The dermatology group indicated: “while I see it being difficult, I could see the merit to sub-reporting if it is done well.”
- “Sub-group reporting has the potential to make MIPS more meaningful to our sub-specialists, but there are pitfalls.” For example, there are “not enough quality measures available for eCQM reporting for specialists...to build more eCQMs is a daunting task and would take [our EMR] several years to build.”
- Sub-group reporting would “deter[] from a team approach to patient care, makes departments more competitive, and it does nothing to improving care for the patient.” It would be “costly and stressful” to implement multiple MIPS reporting schemes across various departments.

Upon consideration of this information, we remain concerned about the feasibility of sub-group reporting. While there may be some benefit to allowing sub-group reporting on quality measures for certain group practices, it is unclear whether this benefit would outweigh the other problems created by this concept, such as with promoting interoperability measures and operational concerns.

In summary, it is unclear whether the MVP framework would substantially change the MIPS reporting landscape to merit support of policies to allow sub-group reporting. We would be more open to this concept should CMS implement our suggestions around reducing burden in the promoting interoperability category through allowing attestation to CEHRT use and outlined more concrete proposals as to how sub-group reporting would work from an operational standpoint.

Scoring

CMS request: What scoring policies can be simplified or eliminated in MVPs, how to create quality across MVPs, and how to score multispecialty practices.

MGMA comment: As MGMA has suggested in the past in response to MIPS scoring policies, we recommend that CMS assign MIPS performance category weights equal to the number of points they represent in the final score to minimize confusion. Specifically, CMS should align points with scoring

and eliminate the use of percentages within each category, which would eliminate the need for physicians to perform complicated calculations to determine scores in each performance category.

Population health quality measure set

CMS request: The agency plans to increase the use of global and population administrative claims-based quality measures and to develop a population health quality measure set, with at least one additional administrative-claims based measure beginning in performance year 2021.

MGMA comment: We continue to disagree with the application at the individual physician or practice level of claims-based population-level measures.

Clinician data feedback

CMS request: Is there particular quality and cost measure data that would be helpful; would it be useful to have feedback based on an analysis of administrative claims data that includes outlier analysis or other types of actionable feedback; what type of information about practice variation, such as the number of procedures performed compared to other clinicians with the same specialty or treating the same type of patients would be most useful.

MGMA comment: Providing timely, actionable claims data could help MVP participants to immediately improve care and reduce costs, which could also translate into designing effective APMs, furthering the intent of MVPs to ease the transition of MIPS participants into an APM. CMS could partner with its Technical Support contractors to assist physicians with accessing and reviewing claims data. The claims data could be similar to what ACO participants are provided, such as patients' utilization and spending for Medicare covered services, not just the services that are provided directly by the practice. Using this claims data, they would be able to see where the best opportunities are to better coordinate their patient care and lower avoidable costs, which could help them decide if APM participation is right for them, see who else needs to be included as participants to capture the other professionals or facilities that their patients are utilizing, and help them gain experience in the generating savings through care improvements before they are actually part of an APM. Consider performance results from ACOs in the MSSP; 2017 results showed that it takes several years in order for ACOs to produce consistent savings, indicating that experience in the program is a predictor for success. Opportunity to receive similar data as what is provided to MSSP ACO participants would give practices the opportunity to evaluate this data in a manner that allows them to make adjustments to workflows or patient care that sets them up for success if they do decide to join an APM, and may put them on a faster track toward success.

Particularly with respect to cost measurement, MGMA regularly hears from members that clinicians and group practices do not understand how CMS evaluates them on resource use and that the lack of actionable, timely information makes this category a "black box" that they have little to no control over. MGMA members have recommended that the agency provide information on the number of procedures a clinician performs comparative to peers, as well as information regarding the costs of certain episodes of care, such as procedures or visits following a procedure such as surgery. With MVPs in particular, it will be critical that CMS provide this type of comparative data so that clinicians can see where they fall on costs compared to their peers.

MIPS Score and Payment Adjustments

Performance threshold

CMS proposal (84 Fed. Reg. 40800): CMS proposes to increase the MIPS performance threshold to 45 points in performance year 2020 and to 60 points in performance year 2021. CMS also proposes to increase the exceptional performance threshold from 70 points to 80 points in 2020 and to 85 points in 2021.

MGMA comment: MGMA does not support the proposal to increase the performance threshold from 30 points in 2019 to 45 points in 2020. Particularly as clinicians and group practices are still adjusting to MIPS, we encourage CMS to allow them to gain experience in the program when setting the performance threshold. Moreover, as reporting requirements, measure specifications, category weights, and other key details have changed year-over-year since the program's inception, CMS should introduce stability and predictability by establishing an appropriate threshold and refrain from constantly escalating it.

Moreover, a reporting threshold of 45 points exceeds the mean and median final MIPS score for small group practices for the 2017 performance period, the only year in which CMS has published detailed aggregate performance results as of the date these comments were submitted. The 2017 experience report (Table 20), which provides information about aggregate performance during the 2017 performance year, indicates that small practices achieved a mean final score of 43.46 and median final score of 37.67. CMS must take steps to ensure that small practices are able to meaningfully participate in MIPS and are not significantly disadvantaged compared to their larger group peers.

In order to achieve a threshold score of 45 points based on 2020 MIPS category weights, small group practices must report to more than one MIPS category. While this may not seem like a significant burden, MGMA has heard from small groups that have either not transitioned to an EHR or to an EHR with the requisite CEHRT and therefore have limited participation options. Moreover, EHR vendors often impose added costs for MIPS reporting functionalities, which forces small groups to either accept reporting fees upfront and hope they score well enough to offset these costs with subsequent payment adjustments, or potentially accept a penalty if reporting levels are not sufficient in categories that do not require EHR technology or EHR technology submission.

Bonus points

CMS proposal (84 Fed. Reg. 40793): CMS proposes to maintain the complex patient bonus of up to five points added to the final MIPS score as well as the small practice bonus of six points included in the quality performance category score.

MGMA comment: MGMA appreciates that CMS intends to maintain the complex patient and small practice bonuses in 2020. However, we encourage CMS to move all program bonus points, including the small practice bonus, to the overall MIPS score.

For the 2018 performance period, CMS automatically added five points to the final MIPS score of solo practitioners and group practices consisting of 15 or fewer eligible clinicians that submitted at least one MIPS data point. In 2019, CMS moved the small practice bonus from the overall MIPS score to the quality category. Although CMS did not propose any refinements to the small practice bonus for 2020, we encourage the agency to adopt the policy finalized for the 2018 performance period and apply the five-point adjustment to small practices' overall MIPS score, rather than the six-point quality category bonus. Since CMS has already implemented the small practice bonus at the aggregate MIPS performance score level, the agency could finalize this policy again for 2020 without seeking comment through the 2020 proposal.

The factors addressed in the small practice bonus are broadly applicable to the individual or group's participation in the program, not just the quality component, and therefore this bonus would be more accurately reflected if added to the overall score. Additionally, having all bonuses apply at the same level—the overall score—simplifies scoring methodologies.

Redistributing performance category weights

CMS proposal (84 Fed. Reg. 40797): CMS proposes to revise its policy for redistributing the weights of performance categories in the event that a scoring weight that is different from the generally

applicable weight is assigned. Starting in performance year 2020, CMS would no longer increase the weight of the improvement activities category above 15% in re-weighting scenarios. In situations where both the quality and promoting interoperability categories are re-weighted to 0%, CMS would redistribute the collective 85% into the cost component of MIPS.

MGMA comment: MGMA strongly opposes this policy. While CMS conveys that this re-weighting policy would only apply in very limited circumstances, MGMA is aware of scenarios wherein a practice was unable to report both quality and promoting interoperability data based on EHR or vendor issues during the 2017 or 2018 reporting years. In these scenarios, or in scenarios where a practice encounters a significant hardship and is entitled to exemption from quality and promoting interoperability, the practice would only be able to report improvement activity data and be measured on cost. These practices may have already undergone a catastrophic event or other hardship and should not be further penalized or disadvantaged by having the cost component weighted so heavily. For the reasons set forth in our comments on the cost component of MIPS, MGMA has significant concerns regarding cost measurement and therefore does not believe it is equitable or fair to measure a clinician almost entirely based on cost measures. Moreover, a practice may only have one cost measure attributed to them, which would mean one measure could account for 85% of their score. We strongly urge CMS not to adopt this policy and to instead distribute the quality and advancing care information category weights into the improvement activities category and maintain cost at its generally applicable weight in the event that such a re-weighting situation apply.

Quality Category

Data submission criteria

CMS proposal (84 Fed. Reg. 40746): CMS proposes to reduce the quality category weight from 45% in 2019 to 40% in 2020, adding the 5% difference to the cost category. Clinicians and groups would continue to report six quality measures, including at least one outcome measure (or high-priority measure if no outcome measure is available), or one specialty measure set.

MGMA comment: We do not support CMS reducing the quality category to 40% of a clinician or group's final score in 2020. Congress afforded CMS flexibility through the Bipartisan Budget Act of 2018 to set the performance threshold and category weights, and MGMA urges CMS to follow congressional intent. Decreasing the weight of the quality component to redistribute the weight to the cost component prematurely leads to less stability and predictability.

MGMA continues to recommend the agency reduce the reporting burden in the quality category by decreasing the number of measures that must be reported to allow clinicians to focus on the most relevant measures to their patients, better aligning this category with the Meaningful Measures initiative.

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 quality measure 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.

Moreover, we recommend that CMS make reporting an outcome or high priority measure optional, rather than mandatory. The agency could continue to incentivize reporting outcome measures by awarding MIPS bonus points or cross-category credit, such as in the improvement activities category or promoting interoperability category if reported using CEHRT. The outcome or high priority measure requirement disadvantages certain specialties that may have a limited inventory of clinically relevant measures. While CMS may identify several outcome or high priority measures that could be reported by a given specialty, there may be technical, operational, or practice-specific limitations that interfere

with a clinician or group's ability to submit data for that measure.

Data completeness threshold

CMS proposal (84 Fed. Reg. 40747): CMS proposes to increase the data completeness requirement for quality measures from 60% to 70% of applicable patient encounters, including patients covered by private payers if reporting via registry, QCDR, or EHR. CMS seeks feedback on alternative policies to the proposal to increase data completeness to 70%, such as whether to increase data completeness to 80%.

MGMA comment: We strongly oppose any proposal that increases quality measure data completeness requirements beyond the current 60% threshold. Even under the defunct PQRS program, the reporting threshold for most reporting options was set at 50% of applicable patients. While the quality component of MIPS reduces the number of required measures from the nine required in PQRS to six, an increase in the data completeness threshold negates burden reduction and is counter to CMS' "Patients over Paperwork" initiative.

Rather than implement quality measure policies that establish data completeness thresholds based on a percentage of patients that meet a measure's denominator criteria, MGMA recommends CMS consider alternatives that would reduce administrative burden and simplify reporting. For example, CMS should consider moving to a threshold based on a minimum number of patients or other predictable methodology. Using a percentage-based threshold requires practices to do the impossible: predict their patient population at the start of the performance period to determine whether they would meet requisite thresholds for six separate measure denominator criteria.

Using a minimum number of patient policy offers greater predictability and stability for group practices. For cost measures, the agency generally requires only 10, 20, or 35 patient encounters to meet a reliability score of 0.4. For quality measures, MGMA encourages CMS to consider a data completeness threshold that meets a minimum reliability score of 0.80, which would increase the confidence that clinicians and groups have on their quality measure performance scores and comparisons. Moving to a minimum number of patients or some other predictable methodology also facilitates the planning of resources and staffing required for this effort.

We have heard from MGMA members about a variety of scenarios that could frustrate meeting higher data completeness standards. For example, group practices that have multiple practice locations have reported frustration with meeting data completeness requirements for quality measures because they either have to pay their EHR vendor to aggregate patient data across multiple sites of service (or across multiple EHR products) or rely on data gathered at one site of service, which may put them at risk of falling below the threshold. MGMA has also heard from practices that utilize a registry or QCDR that excludes certain clinician types, which frustrates their ability to report and submit complete data. For example, one practice noted that their CRNAs are not able to report through their registry and they must manually re-create the details of each patient case, securely upload it, and then have the vendor create a survey file of numerator and denominator codes to transmit to CMS on top of the physician-level data gathered through the registry.

While CMS contends that lower data completeness levels could allow for "cherry-picking" or selective reporting of data, the agency should sanction vendors that engage in practices that compromise the reliability or validity of measure scores rather than punish clinicians and groups with higher reporting thresholds.

Administrative claims measures

CMS proposal (84 Fed. Reg. 40750): CMS proposes to continue to measure the all-cause hospital readmission rate for groups with 16 or more clinicians who meet the 200-case minimum. CMS seeks comment on implementing a core measure set using administrative claims-based data that can be

broadly applied to communities or populations and on the development of measure set tracks around specialty areas or public health conditions.

MGMA comment: MGMA reiterates our continued opposition to CMS' use of the all-cause hospital readmission measure for group practices with 16 or more clinicians who meet the case minimum. This measure and those associated with the Hospital Readmission program 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 value-based payment modifier (VBPM) patient attribution methodology, they often hold practices and clinicians accountable for patient outcomes they had very little control or influence over. Inadequate risk adjustment and lack of consideration of social risk factors is a continued concern. Until CMS improves measure evaluation and implements key refinements, clinicians should not be held accountable for this measure. Instead, CMS should refine and then test a revised all-cause readmission measure by making it optional in the improvement activities category, at least until these underlying problems can be studied and addressed.

We do not support CMS' proposal to create a new administrative claims measure starting in CY 2021 for all cause unplanned admissions for patients with multiple chronic conditions.

Measure removal

CMS proposal (84 Fed. Reg. 40751): CMS proposes to remove 55 quality measures in 2020 and also proposes a new policy on measure removal and would eliminate measures that do not meet the case minimum or volumes required for benchmarking for two consecutive years.

MGMA comment: MGMA opposes the proposal to implement a measure removal policy due to low reporting rates, as this could discourage the development of new quality measures. New measures will not have a historic benchmark for two years, thus by removing a measure after two years of low reporting, CMS is not allowing the opportunity to develop a benchmark for new measures. In essence, a measure may have a low reporting rate *because* it lacks a benchmark, rather than the measure not being a meaningful metric to clinicians.

Under current policy, measures without a benchmark, which includes new measures, will not receive a score above three points. Therefore, the availability of a measure benchmark is an important factor for group practices selecting measures to report at the start of a performance year.

To incentivize reporting on new measures, CMS should change the policy for scoring such measures rather than simply removing them if they have low reporting rates. CMS should move to pay-for-reporting on new measures for the first two years a measure is introduced into the program and/or significant refinements to the measure have been made. There is already precedent for CMS to allow pay-for-reporting on new measures in other value-based programs. By incentivizing clinicians to test new measures, CMS is more likely to have sufficient data to calculate benchmarks, which could ultimately lead to more robust reporting on that measure in future years and negate the need for the removal of certain measures. While MGMA understands that measures with continued low reporting may merit removal, we encourage CMS to establish a different timeframe than the proposed two-year approach. CMS should consult with measure stewards to establish a different timeframe that does not discourage measure development and reporting on new measures.

CMS also proposes to remove 55 measures for 2020, which includes several outcome and high priority measures. It is difficult enough for certain specialties to find six cost measures to report on, however it is even more difficult to ensure that one of those measures meets the outcome or high priority measure criteria. In addition to taking a more deliberate approach to measure removal that considers impact to each specialty, MGMA reiterates our opposition to the requirement that clinicians report on an outcome or other high priority measure.

Medicare Part B claims reporting option

CMS proposal (84 Fed. Reg. 40855): CMS proposes to maintain claims-based reporting for small practices but proposes to limit this option to only clinicians or groups who submitted data via claims submission in 2017.

MGMA comment: We support CMS maintaining the claims-based reporting option for the 2020 performance period, however we do not support limiting the option to only those clinicians or groups that reported via claims in 2017. Newly formed small practices, or practices that may experience operational difficulties with a preferred submission mechanism such as an EHR vendor that encounters technical issues that prevent or frustrate reporting via eCQM, should be permitted to benefit from the claims-based reporting option even if they did not report this way in previous years.

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.

Topped out measures

CMS proposal (84 Fed. Reg. 40750): CMS finalized policies through the CY 2018 QPP rule to remove “topped out” measures after four years of high, unwavering performance and to cap “topped out” measures at 6 of 10 points. In the CY 2019 QPP rule, CMS finalized that it 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: While CMS does not propose significant revisions to its policy regarding topped out measures, MGMA remains concerned that removing and capping measures too quickly, absent a reduction in the quality reporting burden, will lead to further gaps in the measure portfolio. CMS should take a more deliberate approach to measure removal, 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 topped out because the desired outcome has become so commonplace as to warrant the retirement of the quality measure.

MGMA has concerns about CMS’ policy identifying certain measures as extremely topped out and to 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 simply because they 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 and that topped out measures may be their only option. Removing extremely topped out quality measures only exacerbates 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 is premature and disruptive. Neither the health care industry nor CMS has 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.

If CMS retains its policies regarding topped out and extremely topped out measure removal, 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 an extremely topped out measure via claims.

MIPS Cost Performance Category

Cost category weight

CMS proposal (84 Fed. Reg. 40752): CMS proposes to increase the cost performance category weights by 5% over the next three years – 20% in 2020, 25% in 2021, and 30% in 2022. CMS also proposes significant changes to cost measurement in 2020, including adding 10 new episode-based measures and revising the existing total per capita cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measures.

MGMA comment: In the Bipartisan Budget Act of 2018, Congress extended the Secretary's authority 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. In order to improve cost measurement methodology, MGMA urges CMS to weight the cost category of MIPS no higher than 15% in 2020.

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.

We continue to be extremely concerned that comparisons of clinician 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. The problem is worsened by applying a low minimum reliability score (0.4) meaning that accountability for costs will often be attributed inappropriately, particularly for clinicians and groups that are just above the minimum case threshold.

MGMA supports the transition to episode-based measures and believes that cost measures should be centered around specific conditions or periods of care. We appreciate the efforts by CMS and Acumen to facilitate a process that allows for clinical input in cost measure development and refinement. However, the agency should reserve time for any necessary program refinements, including opportunities to fairly assess performance for clinicians and groups who are attributed episode-based cost measures compared to clinicians and groups who are not. Therefore, while the agency continues to introduce new episode-based cost measures, CMS should not increase the weight of this category.

Clinicians do not understand how they are evaluated on MIPS cost measures, and confusion over cost metrics is compounded by year-over-year changes and inadequate feedback. Clinicians feel they have no influence over controlling costs due to the lack of understanding over evaluation.

It is critical that the agency provide timely and actionable specifications regarding these measures. MGMA appreciates improvements made to 2018 cost measure feedback that included demographic information for attributed beneficiaries, costs related to billed services, and acute care utilization. However, we encourage CMS to provide comparative information, such as the number of procedures a clinician performs comparative to peers, as well as information regarding the costs of certain episodes of care, such as procedures or visits following a procedure such as surgery. We have heard from MGMA members that this type of comparative data is helpful in cost reduction as clinicians can see where they fall on utilization compared to their peers.

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.

TPCC and MSPB measures

CMS proposal (84 Fed. Reg. 40757): CMS proposes numerous changes to the TPCC and MSPB measures starting in 2020, including a revised primary care attribution and risk adjustment methodology.

For the TPCC measure, the agency would also add service and specialty category exclusions for clinicians who perform non-primary care services and begin evaluating beneficiary costs on a monthly basis rather than annual basis. The agency also proposes a service exclusion list that is considered clinically unrelated to the index admission of the revised MSPB clinician measure.

MGMA comment: MGMA has continually expressed concern over the TPCC and MSPB measures since they were included in the VBPM program and we continue to urge CMS to retire these measures from MIPS. Measure revisions proposed for 2020 retain flawed methodologies as well as create new problems.

If CMS does not remove the TPCC and MSPB measures for 2020, we urge the agency to address attribution and risk adjustment methodologies, as well as the policy that double counts costs across multiple measures and/or multiple clinicians. The proposed revisions to the TPCC measure would retain the flawed approach that holds clinicians accountable for patient treatment costs even long after the patient has left their care.

The new attribution methodology would establish a primary care relationship after a candidate event and begin a year long risk-window wherein the clinician is responsible for all subsequent treatment costs, even if the patient leaves the practice and pursues treatment elsewhere. We appreciate that CMS is proposing to no longer hold clinicians responsible for patient costs incurred before the clinician even saw the patient, however establishing a risk window that fails to identify the end of a clinical relationship generates new concerns over clinicians being held responsible for costs long after the patient has left their care.

CMS also proposes revisions to better identify those clinicians that provide primary care services by establishing exclusion criteria for specialties that are not ordinarily responsible for primary care. Establishing an attribution exclusion based on specialty designation has the potential to create confusion for specialty practices that employ NPPs, who do not have a specialty designation with Medicare. Therefore, while CMS may intend to exempt a particular specialist from attribution, a group of these clinicians could ultimately be attributed patients if the group practice employs NPPs that furnish an E/M visit, which could count as a candidate event and trigger attribution. This policy has the potential to generate significant confusion for group practices that believe they would be excluded from having patients attributed to them under this measure.

We also have significant concerns about policies that would “double count” costs. First, CMS will potentially attribute one patient and associated treatment costs to multiple clinicians across separate group practices. Second, TPCC and/or MSPB measure costs could also be included in evaluation of episode-based measures if an episode-based measure applies to a clinician or group practice.

Episode-based measures

CMS proposal (84 Fed. Reg.): CMS proposes to move forward with the inclusion of 10 new episode-based cost measures for implementation in 2020. These cost measures are attributed to clinicians who provide a trigger service for procedural episodes or bill inpatient E/M claims for chronic inpatient episodes. The Lower Gastrointestinal Hemorrhage measure is only proposed for group reporting.

MGMA comment: While we support the move toward episode-based measures and away from the flawed measures retained from the VBPM program, we encourage CMS to create a softer glidepath for new measures. This may include making such measures informational during the first year of implementation, making measures voluntary with the option to receive bonus points for those clinicians or groups that voluntarily agree to have them included in their score, and/or setting a higher minimum episode threshold during the initial years of implementation.

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 Improvement Activities Category

Group reporting threshold

CMS proposal (84 Fed. Reg. 40763): CMS proposes to increase the participation threshold for MIPS reporting at the group or TIN level from one clinician to a minimum of 50% of the clinicians in the group practice.

MGMA comment: MGMA strongly opposes the 50% threshold proposal, as well as any arbitrary percentage-based threshold for group reporting of improvement activities. Instead, the Association urges CMS maintain the existing policy allowing for a single clinician within a group practice to perform an improvement activity in order for the group to receive credit. Implementation of a 50% threshold erodes the welcomed flexibility in the improvement activities category that permits clinicians to select activities meaningful to their own clinical practice. Moreover, given the year-over-year changes to the quality, cost, and promoting interoperability categories, group practices have enjoyed the consistency and reliability of improvement activity policies.

While many improvement activities may entail involvement from many or all clinicians within a group practice, several do not, and imposing such a threshold would discourage the reporting of certain activities or worse, discourage group-level reporting. Sometimes it is not feasible for the majority of clinicians within a group practice to use a QCDR, which would preclude or frustrate the ability for such groups to report improvement activities that involve QCDR usage at the group-level. For example, one multispecialty group practice comprised of optometrists, retinal specialists, and ophthalmologists reported they only have 4 out of 10 physicians reporting through a QCDR due to their scope of clinical practice and availability of relevant QCDR measures. Imposing a 50% threshold would prevent this practice from reporting any of the improvement activities that entail QCDR usage if they wish to report at the group level.

Aside from this example, there are several improvement activities that are clearly geared toward individual participation. For example, it would be impractical to require 50% of a group practice to report IA_ERP_2 (Participation in a 60-day or greater effort to support domestic or international

humanitarian needs); having 50% of the clinicians within a group practice absent from the practice for 60 or more days is not only disruptive to the care of patients in the home office, it is impractical to expect that 50% of clinicians within one group are capable of fulfilling this important activity.

Patient-centered medial homes

CMS proposal (84 Fed. Reg. 40763): CMS proposes that practices designated as a certified PCMH will continue to receive automatic credit for the improvement activities category but proposes a revise the definition of which models qualify. In previous years, CMS enumerated four accrediting organizations that practices must receive accreditation from to be considered a PCMH. Starting in 2020, CMS proposes to update the PCMH guideline so that it is no longer exclusive to those specific accrediting organizations.

MGMA comment: MGMA supports this proposal and urges CMS to finalize it.

MIPS Promoting Interoperability Category

CMS proposal (84 Fed. Reg. 40795): “In general, 30 percent for the quality performance category; 30 percent for the cost performance category; 25 percent for the Promoting Interoperability performance category; and 15 percent for the improvement activities performance category.”

MGMA comment: In addition to earning bonus points in the quality performance category, 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 (PI) 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 PI 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 PI 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.”

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

CMS proposal (84 Fed. Reg. 40796): MIPS eligible clinicians who fail 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 that the agency has proposed to continue the “all or nothing” methodology for the MIPS PI 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 PI category. We urge CMS to discontinue this tactic and permit ECs to score points in any of the PI performance objectives and measures.

Scoring methodology

CMS proposal: CMS is proposing to continue its 2019 scoring methodology for the 2020 performance period.

MGMA comment: While we appreciated the intent of the 2019 PI component to decrease the administrative challenges associated with ECs participating in the PI 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 2020, many clinicians would have been utilizing CEHRT for as many as nine 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 PI 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. As stated earlier, 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 the previously-required 2014 Edition and the currently-required 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 PI requirements and be awarded the full 25 PI 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 2020 PI 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 PI program for the 2020 reporting period should be simplified by creating the following approach:

Objective	Measure	Promoting Interoperability Points using 2015 CEHRT
Using 2015 CEHRT	Attest to have adopted 2015 CEHRT	20
e-Prescribing	Attest to have e-prescribed at least once during the reporting period	10
Provide Patients Electronic Access to their Health Information	Attest to have provided at least one patient electronic access to their health information	10
Conducting a Security Risk Analysis	Attest to have completed a Security Risk Analysis at least once during CY 2020 (if this measure continues to be required in 2020)	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
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information. Attest to have sent at least one summary of care document in	20

	support of a transition of care or referral using CEHRT	
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
Public Health and Clinical Data Exchange	Clinician is in active engagement	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
e-Prescribing	Verify Opioid Treatment Agreement. A numerator of at least one is required to fulfill this measure.	10 bonus points

Regardless of what specific objectives and measures are adopted, for the 2020 reporting period CMS should apply the same 50-point scoring standard finalized for the 2020 Inpatient Meaningful Use Program to the MIPS PI. Thus, ECs who earn 50 points or higher in MIPS PI should be deemed to have satisfied the PI category’s requirements. These ECs should receive 100 points in the PI 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 PI score (i.e., an EC scoring 30 PI points would receive 7.5 MIPS composite score points).

The above approach would address several critical issues. First, the PI component of MIPS would cease being an “all or nothing” approach with ECs able to select among the measures within an objective that best meets 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 PI score. 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 PI period, ECs or groups attesting to implementing 2015 Edition CEHRT and that they have not turned off any of the PI features should be deemed to have met the PI requirements and awarded the full 25 PI points. Adopting this approach would serve as a significant incentive for those who have yet to upgrade from 2014 CEHRT and avoid 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 the potential points of that measure (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.

e-Prescribing measures

CMS proposal (84 Fed. Reg. 40775): “...in the event we finalize the proposal for the Query of PDMP measure; and (3) remove the Verify Opioid Treatment Agreement measure beginning in 2020...”

MGMA comment: We agree with the agency’s proposal to eliminate the Verify Opioid Treatment Agreement measure from the 2020 program. 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 PI component 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.

PDMP scoring

CMS proposal (84 Fed. Reg. 40868): “...we propose to allow clinicians to satisfy the optional bonus Query of PDMP measure by submitting a “yes/no” attestation...”

MGMA comment: We are supportive of the CMS decision to make the Query of Prescription Drug Monitoring Program and Verify Opioid Treatment Agreement measures optional in 2020. We urge that these measures be optional in 2021 as well. 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).

We remind CMS that 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.

In addition, we agree with the agency to permit clinicians to satisfy the optional bonus Query of PDMP by submitting a yes/no attestation.

HIPAA Security Risk Analysis

CMS proposal: CMS continues to 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 PI 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 Figliozzi), 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 of these areas to ensure they have implemented an adequate security infrastructure.

Health Information Exchange measures

CMS proposal (84 Fed. Reg. 40770): "There are two measures under the Health Information Exchange objective: The Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Incorporating Health Information Measure."

MGMA comment: Requiring an EC or group to report the Support Electronic Referral Loops by Receiving and Incorporating Health Information objective continues to add 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 CEHRT, 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.

With the objective required in 2019 and proposed to be required for 2020, MGMA continues to have 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.

Public Health and Clinical Data Registry measures

CMS proposal (84 Fed. Reg. 40774): Currently, 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, 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 continue to support expanded options for fulfilling the Public Health Reporting objective and 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 continue to oppose the “two-for-one” proposal for 2020 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.

Provide Patients Access objective

CMS proposal (84 Fed. Reg. 40772): For the Provider to Patient Exchange objective, CMS uses 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 login to 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 (84 Fed. Reg. 40866): "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, clinicians who are in a small practice, and decertified EHR technology."

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 policy of relying on this statutory provision to assign a 0% weighting to PI for ECs who demonstrate that reporting PI 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, further complicating the decision-making process.

We are concerned, however, with the agency's current requirement that the MIPS eligible clinician "make 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 incurs additional cost and time for implementation and testing. 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 PI performance category reweighted to zero.

While we support the existing hardship exceptions for 2020 and continue to support the agency's plan to re-weight the PI 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 PI 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 PI 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.

Advanced APMs

MGMA is encouraged by recent announcements from CMS creating new APMs such as the Primary Care First, Direct Contracting, and voluntary kidney care models. To continue expanding the Advanced APM pathway in 2020 and beyond, we encourage the agency to revise the APM risk standard to account for the investment and operational risks inherent in moving from fee-for-service to risk-bearing arrangements. CMS has discretion under the MACRA statute to revise the APM risk standard.

We urge CMS to work directly with the physician community to develop new models of care delivery and episode payments and accelerate the APM approval process. We also encourage CMS to continue to seek opportunities to adopt private sector payment models and PCMH models as Advanced APMs. Some of the most innovative and successful APMs are being developed and deployed by the private sector.

Partial QP

CMS proposal (84 Fed. Reg. 40827): CMS proposes to apply partial QP status at the TIN/NPI level, rather than at the NPI level as it is currently applied. Beginning with the 2020 performance period, partial QP status would only apply to the TIN/NPI combination through which an individual attains partial QP status. A clinician who participates with other TINs, under which the clinician does not attain QP or partial QP status, would be required to report for MIPS unless exempt under the low-volume threshold.

MGMA comment: MGMA opposes this proposal. This change would result in significant confusion for clinicians that practice at multiple TINs and administrative professionals overseeing MIPS

reporting requirements and payment adjustment application. The current policy around attaining “full” QP status, which applies across all TINs in which a clinician practices under, should also apply to partial QPs to streamline and simplify QPP policies. Particularly as the threshold to become a QP increases over time, more clinicians in Advanced APMs will be deemed a partial QP. To have these clinicians potentially exempt at one practice but required to report for MIPS at a second practice is unnecessarily confusing and burdensome from an administrative standpoint.

Under the current policy, partial QPs may voluntarily report for MIPS and receive a payment adjustment. This affords them appropriate flexibility and the opportunity to receive a positive incentive for participating in MIPS but does not require them to participate or face a payment penalty. MGMA urges CMS to retain its current policy for partial QP status.

Conclusion

We appreciate the opportunity to share our comments regarding the proposed changes to the Medicare PFS and QPP 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 Mollie Gelburd at mgelburd@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs