September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program [CMS - 1784 - P]

Dear Administrator Brooks-LaSure:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the calendar year (CY) 2024 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule, published in the *Federal Register* on Aug. 7, 2023.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups comprising more than 350,000 physicians. These groups range from small independent practices in remote and other underserved areas to large regional and national health systems that cover the full spectrum of physician specialties.

Key Recommendations

MGMA appreciates the Centers for Medicare & Medicaid Services' (CMS) leadership in improving Medicare and respectfully offers the following comments in response to the CY 2024 PFS proposed rule. In summary, we encourage the agency to:

- **Urge Congress to provide a positive update to the Medicare conversion factor in CY 2024 and all future years.** MGMA is deeply concerned with the estimated reduction to the CY 2024 conversion factor and its potential impact on medical group practices. The cuts stemming from the 3.36% decrease to the CY 2024 conversion factor paired with the current inflationary environment are simply unsustainable. In an MGMA poll conducted in August 2023, 95% of medical practices reported that the projected reduction to 2024 Medicare payment would negatively impact their ability to deliver timely, high-quality care to patients.[1]

- **Provide further clarity and guidance surrounding the utilization of HCPCS code G2211.** For CMS to properly implement this code, the agency must further refine its utilization assumption, clarify ongoing questions surrounding utilization of the code, and share robust guidance with the provider community.

[1] MGMA 2024 Proposed Medicare Physician Fee Schedule Questionnaire, August 2023.

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- **Finalize many of the telehealth proposals, including continued reimbursement of telehealth services at the non-facility rate.** Medical groups continue to utilize telehealth services to best serve their patients. In an August 2023 MGMA poll, 81% of medical groups reported that reimbursement for telehealth services at the facility rate would deter them from offering these services.

- **Finalize the proposal to continue defining "substantial portion" for purposes of split or shared E/M services to better reflect the team-based approach to care utilized by medical practices.** MGMA appreciates the proposed delay through 2024 and urges CMS to adopt CPT guidelines for determining when a physician may report a split or shared E/M visit.

- **Move forward with the proposal to continue issuing prescriber notices of non-compliance rather than financially penalizing clinicians who fail to meet the requirements.**

- **Finalize the proposal to reevaluate and rescind the appropriate use criteria (AUC) program regulations.** Following concerns raised by MGMA and other stakeholders regarding the AUC program, we are encouraged that the agency acknowledges the implementation challenges involved and proposes to rescind the regulations.

- **Do not finalize Medicare enrollment proposals to shorten the 30-day revocation window and not pay providers for services furnished during the "stay of enrollment."** We urge CMS to review whether expanding Medicare revocation to include misdemeanors will have unintended consequences.

- **Do not move forward with requiring Promoting Interoperability reporting within the Medicare Shared Savings Program (MSSP).** This requirement is not only being implemented too quickly as it will negatively impact participation next year, but the policy is overly burdensome, and works against incentivizing participation in the MSSP and the intention of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA).

- **Finalize many of the MSSP proposals including the introduction of the Medicare CQM collection type**. We support establishing the Medicare CQM to report under, and recommend CMS continue to review its proposed transition to all payer/all patient reporting under eCQMs and MIPS CQMs due to current structural technological impediments and other concerns. We appreciate CMS incorporating stakeholder feedback and proposing numerous changes to encourage participation in the MSSP.

- **Do not finalize the proposal to increase the MIPS performance threshold from 75 points in 2023 to 82 points in 2024**. CMS should revise its methodology to avoid this untenable increase to the MIPS performance threshold. The agency's own estimates suggest that over half of MIPS eligible clinicians will be penalized. We strongly urge CMS to reduce the performance threshold and work to alleviate the overwhelming burden of MIPS during the 2024 performance period.

- **Do not finalize the proposal to move from making Qualifying Alternative Payment Model (APM) Participant (QP) determinations at the APM entity level to making the determination at the individual clinician level**. This proposal does not support the transition to value-based care arrangements, increases reporting burden from individual clinicians, and will negatively impact specialty participation in APMs. We recommend CMS continue to make QP determinations at the APM entity level.

- **Work with Congress to reinstate the APM incentive payment at 5%.** The expiration of the current 3.5% incentive payment and transition to a "qualifying APM conversion factor" has the potential to disincentivize participation in APM — contrary to CMS' intention — and negatively impact current APM participants' ability to continue providing value-based care.

Physician Fee Schedule

Conversion Factor

CMS proposal (88 Fed. Reg. 52679): Due to statutory budget neutrality requirements, CMS estimates the 2024 Medicare PFS conversion factor to be $32.7476, a decrease of $1.14, or approximately 3.36%, from the CY 2023 PFS conversion factor of $33.8872.

MGMA comment: MGMA recognizes that CMS is constrained by statutory budget neutrality requirements, however, we remain deeply concerned about the estimated reductions to the conversion factor in CY 2024. MGMA conducted a survey of 517 medical group practices, ranging from small practices to large 2,500 physician health systems, assessing the impact of potential Medicare payment cuts, and evaluating how physician practices would respond to reimbursement cuts. Practices would consider limiting the number of new Medicare patients, reducing charity care, reducing number of clinical staff, and closing satellite locations.[2]

The 3.36% decrease to the conversion factor, paired with the current inflationary environment is untenable. According to the American Medical Association (AMA), between 2001 and 2023, the cost of running a medical practice increased 47%.[3] Adjusted for inflation, during that same time period, Medicare physician payment rates declined by 26%. Moreover, the Medicare Payment Advisory Commission (MedPAC) previously recommended that Congress provide a positive update to the PFS for 2024.[4] MGMA asks that CMS work with Congress and advocate for a positive update to the Medicare conversion factor in CY 2024 and all future years. MGMA supports the passage of the *Strengthening Medicare for Patients and Providers Act* (H.R. 2474), which would provide an annual Medicare physician payment update tied to inflation, as measured by the Medicare Economic Index (MEI).[5]

Telehealth

Implementing the Consolidated Appropriations Act of 2023

CMS proposal (88 Fed. Reg. 52298): The proposed rule makes numerous confirming changes to implement provisions of the *Consolidated Appropriations Act of 2023* (CAA, 2023) which extended certain telehealth flexibilities instituted during the COVID-19 Public Health Emergency (PHE) through Dec. 31, 2024. These include:

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[2] MGMA, Impact of Payment Reductions to Medicare Rates in 2023, Sept. 8, 2022, https://www.mgma.com/federal-policy-resources/impact-of-payment-reductions-to-medicare-rates-in-2023.
[3] AMA, Medicare updates compared to inflation (2001 – 2023), https://www.ama-assn.org/system/files/ama-medicare-gaps-chart-grassroots-insert.pdf.
[4] MedPAC, Mar. 2023 Report to Congress: Medicare Payment Policy, https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/.
[5] Letter to Congress from over 120 medical associations, Apr. 19, 2023, https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fltrf.zip%2FHR-2474-AMA-Federation-Letter-of-Support-4-19-23.pdf.

- Extending geographic and originating site flexibilities;
- Expanding the list of qualifying providers to include qualified occupational therapists, physical therapists, speech-language pathologists, and audiologists. CMS will recognize marriage and family therapists and mental health counselors as telehealth practitioners as well starting Jan. 1, 2024;
- Temporarily allowing audio-only services for certain telehealth services;
- Delaying in-person requirements for mental telehealth; and,
- Continuing payment for telehealth services offered by Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHCs) using the methodology established during the PHE.

MGMA comment: MGMA appreciates CMS making conforming regulatory changes to implement the CAA, 2023, and supports these proposals. These policies have allowed practices to successfully continue providing necessary telehealth treatment. The agency should continue to review how these policies have expanded access to care and work with Congress to craft permanent solutions that extend beyond 2024. We urge CMS to permanently institute coverage and payment for audio-only services. These services offer a lifeline to patients who do not have access to broadband or the necessary technology for audio-visual visits. The agency should exercise its authority to cover these essential audio-only services after 2024.

New process to establish the Medicare Telehealth Services List

CMS proposal (88 Fed. Reg. 52294): CMS proposes to update its process for analyzing which services should be added to the Medicare Telehealth Services List. Specifically, the new process includes the following steps:

1. Determine whether the service is separately payable under the PFS.
2. Determine whether the service is subject to the provisions of section 1834(m) of the Act.
3. Review the elements of the service as described by the HCPCS code and determine whether each of them is capable of being furnished using an interactive telecommunications system as defined in section 410.78(a)(3).
4. Consider whether the service elements of the requested service map to the service elements of a service on the list that has a permanent status described in previous final rulemaking.
5. Consider whether there is evidence of clinical benefit analogous to the clinical benefit of the in-person service when the patient, who is located at a telehealth originating site, receives a service furnished by a physician or practitioner located at distant site using an interactive telecommunications system.

CMS is proposing to consolidate Categories 1, 2, and 3 for all services currently on the Medicare Telehealth Services List. Services that are currently listed under Categories 1 and 2 will be listed as "permanent," while "temporary Category 2" or Category 3 services will be designated at "provisional" for CY 2024.

MGMA comment: MGMA supports CMS' redesignation of Category 1, 2, and 3 services to reduce confusion on what is permanently covered on the Medicare Telehealth Services list. We appreciate the agency's attempt to simplify its process for adding services to the telehealth list, and recommend that CMS continue to review its proposed new process to ensure there are not any unintended hurdles to adding services. We encourage CMS to work with stakeholders to ensure that a wide range of services are included on the Medicare Telehealth Services List, allowing physician practices the ability to render these services virtually when appropriate.

Direct Supervision

CMS proposal (88 Fed. Reg. 52301): The agency would continue to define direct supervision to allow the presence and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications through Dec. 31, 2024.

MGMA comment: We agree with CMS' concerns that there may be potential consequences that result from transitioning to pre-PHE direct supervision policies too quickly. We support the extension of the current supervision policy and urge CMS to consult with practitioners using real-time audio and video interactive telecommunications to find a permanent workable policy that allows flexibility for the various clinical situations that may arise.

Facility Rate vs. Non-Facility Rate

CMS proposal (88 Fed. Reg. 52299): CMS is proposing to reimburse telehealth services billed using the POS 10 code at the non-facility rate through 2024, while claims billed with POS 02 code would be reimbursed at the facility rate in 2024.

MGMA comment: MGMA supports CMS reimbursing telehealth services using the POS 10 code at the higher non-facility rate through 2024. Practices expend significant resources to maintain a telehealth program while also maintaining a physical office, including investing in technological infrastructure and time spent troubleshooting. We urge CMS to continue reviewing its telehealth policies and finalize appropriate, permanent reimbursement rates for telehealth services that accurately reflect the time and cost medical groups incur while providing these vital services.

Home Enrollment for Practitioners

MGMA comment: CMS did not include in the proposed PFS any policies addressing the status of providers reporting their home address when offering telehealth services from their homes. During the PHE, CMS allowed practitioners to render telehealth services from their homes without reporting their home addresses on their Medicare enrollment forms and allowed billing from their currently enrolled location. Following the end of the PHE, CMS continued its policy of allowing providers to continue listing their work address on their Medicare enrollment form while billing telehealth services from their home until Dec. 31, 2023. Over the past few months, the agency updated guidance on its website with conflicting policies, ultimately landing on the extension through the 2023 calendar year.

We urge CMS to make permanent the policy it established during the PHE to appropriately balance protecting providers' need for privacy of their home address with program integrity concerns. Security for practitioners at home is paramount as this information may be publicly available should they be required to report. Allowing practitioners to provide these services without requiring the inspection and reporting of their home address, and safeguarding their privacy outweighs the potential benefits of having practitioners home addresses listed publicly.

E/M Services

Add-on Code (HCPCS Code G2211)

CMS proposal (88 Fed. Reg. 52352): CMS previously finalized E/M add-on code HCPCS code G2211 (*Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or*

established)). Due to its impact on the 2021 PFS conversion factor, Congress previously delayed the implementation of this code through 2023. CMS proposes to implement G2211 in 2024 but readjusted its utilization assumption from 90% in the 2021 rule to 38% (initial implementation) and 54% (full adoption) in this proposed rule. CMS clarifies certain scenarios when G2211 is not appropriate, such as when reported on the same date as an E/M visit reported with modifier -25.

MGMA comment: MGMA has historically agreed with CMS that reimbursement for E/M visits may not always adequately reflect the resources associated with primary care and certain types of specialty visits. While HCPCS code G2211 is a potential avenue to address these concerns, we continue to believe it necessary for CMS to provide more information and overall clarity regarding utilization assumptions of this code due to the meaningful impact it has on the overall budget neutrality adjustment and in turn, the conversion factor. CMS states that approximately 90% of the –2.17% budget neutrality adjustment is attributable to this code. While well-intended, the implementation of HCPCS code G2211 will have a significant impact on the fee schedule, resulting in across-the-board cuts. CMS must revisit its utilization estimate.

In our 2021 PFS comments, we raised a series of questions aimed at better understanding how medical groups should utilize HCPCS code G2211, including seeking guidance around documentation and differentiating when to use this code versus billing a higher-level visit, as well as the typical patient who is expected to receive these services. Lack of clarity may impede medical groups' readiness and/or willingness to use HCPCS code G2211. We anticipate that the lack of education will present challenges to both Medicare contractors and practitioners seeking to bill this code. For CMS to properly implement this code, the agency must further refine its utilization assumption, and share robust guidance around usage with the provider community.

Split or Shared E/M Visits

CMS proposal (88 Fed. Reg. 52354): In the CY 2022 Medicare PFS, CMS finalized a new split or shared E/M policy, defining the "substantive portion" of the visit as more than half of the total practitioner time. Under this policy, a physician would be required to see the patient for more than half of the total time of a split or shared E/M visit to bill for that service. Last year, MGMA and other national healthcare organizations were successful in achieving a one-year delay of this policy. CMS again proposes to delay the implementation of the definition of "substantial portion" for purposes of split or shared billing and to continue to permit the substantial portion of the E/M service to be defined as either history, exam, medical decision-making (MDM), or more than half of total time.

MGMA comment: MGMA appreciates CMS' continued engagement with stakeholders to ensure appropriate billing policies are implemented. MGMA remains concerned that defining "substantive portion" based solely on time does not appropriately reflect the team-based approach to care utilized by many of our member group practices. MGMA urges CMS to finalize its proposal to continuing defining "substantive portion" based on history, exam, medical decision making (MDM), or more than half of total time through 2024.

Across practices and among providers there is significant variability in the time it takes to perform a service. As there is no standardization within a practice among the clinicians, this would create significant billing differences depending on what combination of physician and non-physician practitioners (NPPs) are furnishing the service. MGMA and our member group practices champion team-based approaches to care.

Further, beyond the impact on clinical care, the proposed split or shared E/M billing policy undermines many practices' models of physician compensation. Most practices incorporate productivity measures based on billed RVUs for services. While a physician may perform a majority of the MDM and work in a given service, if an NPP, who may be more inexperienced, takes even a minute longer to support the physician in providing patient care, the NPP will bill for the service. As a result, the practice would not be reimbursed fully for the care provided to the patient.

In March 2022, MGMA and other leading healthcare associations sent a letter to CMS highlighting collective concerns about the split (or shared) billing policy.[6] MGMA urges CMS to adopt the CPT guidelines for determining when a physician may report the split or shared E/M service, following the one-year delay. Adoption of the guidance would support team-based care, allowing for visits to be reported based on time or medical decision-making. The new CPT guidance states:

Physician(s) and other qualified health care professional(s) (QHP[s]) may act as a team in providing care for the patient, working together during a single E/M service. The split or shared visits guidelines are applied to determine which professional may report the service. If the physician or other QHP performs a substantive portion of the encounter, the physician or other QHP may report the service. If code selection is based on total time on the date of the encounter, the service is reported by the professional who spent the majority of the face-to-face or non-face-to-face time performing the service. For the purpose of reporting E/M services within the context of team-based care, performance of a substantive part of the MDM requires that the physician(s) or other QHP(s) made or approved the management plan for the number and complexity of problems addressed at the encounter and takes responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management. By doing so, a physician or other QHP has performed two of the three elements used in the selection of the code level based on MDM. If the amount and/or complexity of data to be reviewed and analyzed is used by the physician or other QHP to determine the reported code level, assessing an independent historian's narrative and the ordering or review of tests or documents do not have to be personally performed by the physician or other QHP, because the relevant items would be considered in formulating the management plan. Independent interpretation of tests and discussion of management plan or test interpretation must be personally performed by the physician or other QHP if these are used to determine the reported code level by the physician or other QHP.

Appropriate Use Criteria Program

CMS proposal (88 Fed. Reg. 52509): CMS proposes to reevaluate and rescind the current appropriate use criteria (AUC) regulations, citing challenges with the claims-based reporting requirements.

MGMA comment: The *Protecting Access to Medicare Act of 2014* created the AUC program, which requires ordering providers to consult a qualified clinical decision support mechanism (CDSM) for applicable imaging services. The AUC program never progressed past the "educational and operations testing period," meaning there were no financial penalties associated with the program. MGMA has long voiced concerns over CMS' ability to implement the program appropriately as well as the cost and administrative burdens associated with program compliance. MGMA appreciates the agency's proposal to reevaluate and rescind the AUC regulations as written, as well as its acknowledgment that many goals of the program have been met by the Quality Payment Program (QPP) and other value-based care initiatives.

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[6] Letter from MGMA and other healthcare organizations to CMS, Mar. 29, 2022, https://www.mgma.com/advocacy-letters/march-29-2022-mgma-and-leading-medical-organizations-urge-cms-to-propose-an-alternative-strategy-for-billing-split-or-shared-visits-2.

If CMS is to ever move forward with the AUC program, MGMA insists that it first be modified to reduce the enormous burden on practitioners and ensure alignment with other CMS programs.

Services Addressing Health-Related Social Needs

CMS proposal (88 Fed. Reg. 52325): CMS proposes coding and payment changes that align with the Administration's HHS Social Determinants of Health (SDOH) Action Plan. Specifically, CMS proposes to pay separately for time-based monthly Community Health Integration (CHI) services, administering a SDOH risk assessment in relation to an E/M visit, and the Principal Illness Navigation (PIN) services. CMS proposes to add the SDOH risk assessment to the annual wellness visit (AWV) as an optional, additional element.

MGMA comment: MGMA appreciates efforts by CMS to better account for resources involved in furnishing patient-centered care in a team-based environment, such as the establishment of HCPCS G-codes and payment rates for time-based monthly CHI services, the establishment of a HCPCS G-code and payment for administering a SDOH risk assessment in relation to an E/M visit, and the establishment and payment for PIN services. While supportive of these efforts, MGMA urges CMS to be mindful of the potential impact these codes may have on payment rates across the board due to budget neutrality requirements. Further, MGMA urges CMS to thoroughly vet and test the SDOH risk assessment tool, as well as consider any potential negative implications that may stem from collecting SDOH data. We support the addition of the SDOH risk assessments to the AWV as an optional element with additional payment.

Electronic Prescribing for Controlled Substances

Timing for Issuing Non-compliance Letters

CMS proposal (88 Fed. Reg. 52531): CMS previously stated that starting in CY 2023 it would begin initial electronic prescribing for controlled substances (EPCS) compliance actions. For 2024, CMS proposes to continue issuing prescriber notices of non-compliance rather than financially penalizing clinicians who fail to meet the requirements.

MGMA comment: MGMA supports CMS' proposal to extend the enforcement policy of sending letters to physician practices who are not in compliance. There are many benefits for medical groups to adopt EPCS in their practices (e.g., workflow efficiencies, public health improvements, increases in patient safety, etc.). However, due to infrastructure and cost challenges, there are prescribers who have not had the ability to upgrade to the technology used for EPCS. We agree with CMS that continuing to send non-compliance notices would support increased EPCS adoption. MGMA reminds CMS that non-compliance alone is not necessarily an indicator of fraud. If CMS implements stricter penalties for noncompliance in the future, MGMA advises that CMS provide sufficient time and support for practices to comply. We additionally appreciate CMS seeking applicants for a new EPCS Program Prescriber User Group — the agency should continue to seek input on the program from stakeholders.

Remote Monitoring Services

Data Collection Requirements

CMS proposal (88 Fed. Reg. 52303): CMS makes certain clarifications regarding remote monitoring services (RMS). CMS clarifies that it will again require that remote patient monitoring (RPM) services be furnished only to established patients, and it will not extend the interim policy to permit billing for remote monitoring codes when less than 16 days of data are collected within a 30-day period. CMS reiterates that

only one practitioner can bill CPT codes 99453 and 99454 or CPT codes 98976, 98977, 98980, and 98981, during a 30-day period, and only when at least 16 days of data have been collected on at least one medical device.

MGMA comment: MGMA appreciates CMS' efforts to increase access to RMS. However, we are concerned that certain clarifications will inhibit medical groups' abilities to utilize these services to their full extent. MGMA appreciated CMS' exception to the 16-day monitoring requirement for RMS during the PHE. While we understand that this flexibility was not extended beyond the PHE, we are concerned that CMS' clarification in this rule will further restrict access to these services. We disagree that the 16-day monitoring requirement is applicable to remote physiologic monitoring treatment management (RTMTM) services (CPT codes 98980, 98981). RTMTM services are distinct from RPM and RTM services, which do require the 16-day monitoring requirement per CPT guidelines. The CPT Editorial Panel purposefully left the guidance flexible to allow medical groups to account for the time and resources spent on patient care.

MGMA recommends that CMS revisit its policy that only one physician or other qualified healthcare professional (QHP) may report CPT codes 99453, 99454, 98976, 98977, 98980, and 98981 during a 30-day period. We are concerned that this will interfere with medical groups' ability to deliver comprehensive patient care — unintentionally limiting treatment for patients who see different practitioners for separate episodes of care.

MGMA supports the usage of RMS and encourages CMS to put forth policies that do not inhibit medical groups' ability to utilize these services. The adoption of RMS services in recent years has shown the potential for significant savings in healthcare spending. According to the Centers for Disease Control, 90% of the nation's healthcare expenditures are for treating chronic healthcare conditions.[7] Further, the University of Pittsburgh Medical Center found RPM services helped to reduce readmission rates by 76%.[8] The flexibility allowed during the PHE demonstrated the full potential of RTM and RPM services.

An internal medicine practice in a metropolitan area in Georgia shared with MGMA how beneficial RMS are to their Medicare patient population, allowing them to better manage chronic conditions and prevent patients from costly hospital admissions. A large portion of patients could benefit from remote monitoring services — of their 40,000 patients, at least 65% have one chronic condition and 35% have at least two or more. The practice further cited challenges with continuing to provide these essential services with the 16-day requirement in place, limiting their ability to fully utilize the potential of these services. MGMA encourages CMS to revisit clarifications that would hamper practices' ability to utilize these services to their full potential.

New vs. Established Patient Requirements

CMS proposal (88 Fed. Reg. 52304): CMS will again require that RPM services be furnished only to established patients following the end of the PHE. CMS clarified that patients who received RMS during the PHE are considered established patients.

MGMA comment: MGMA appreciates the flexibility provided during the PHE in allowing new patients to receive RPM services and believes that rolling back this flexibility is not only short-sighted, but

[7] See the National Center for Chronic Disease Prevention and Health Promotion, https://www.cdc.gov/chronicdisease/about/index.htm.
[8] Insider Intelligence, *The technology, devices, and benefits of remote patient monitoring in healthcare industry*, Jan. 19, 2023, https://www.insiderintelligence.com/insights/remote-patient-monitoring-industry-explained/.

dangerous. Since the agency clarified that RPM services can be furnished to patients with both chronic and acute conditions, it is logical that physicians should be able to utilize RPM services for new patients who present with acute illness. Allowing new patients to utilize RMS has the potential to prevent symptoms from worsening into more dangerous and costly conditions. MGMA urges CMS to allow physicians and QHPs to furnish RPM services to new patients as well as established ones.

Enrollment

Misdemeanor Convictions

CMS proposal (88 Fed. Reg. 52516): CMS proposes to add the conviction of a misdemeanor under Federal or State law within the previous 10 years as a reason for revocation.

MGMA comment: While MGMA agrees that CMS should safeguard the Trust Funds' integrity and the health and safety of beneficiaries, we are concerned about the unintended consequences of expanding the revocation of a provider or supplier's enrollment due to a misdemeanor. This authority could be misused to revoke the enrollment of a provider or supplier when the misdemeanor conviction took place years before they were employed by the provider or supplier and/or were convicted of a misdemeanor unrelated to the Medicare program or its beneficiaries. We suggest the revocation authority only be used if a convicted misdemeanor poses an immediate danger to a patient or the security of the Medicare program.

Timeframes for Reversing a Revocation

CMS proposal (88 Fed. Reg. 52519): CMS is proposing to reduce the timeframe for reversing a revocation from 30 days to 15 days. Revocation can be reversed under current law if the provider or supplier terminates its business relationship with the party within 30 days of the revocation notification.

MGMA comment: MGMA strongly urges CMS to maintain the 30-day period. Fifteen days is too short of a timeframe for a medical group to take the steps needed to conduct the due diligence necessary to consider and carry out such a termination of a business relationship and submit proof of this termination to CMS.

Stay of Enrollment

CMS proposal (88 Fed. Reg. 52520): CMS intends to introduce a new 60-day "stay of enrollment" designation that would delay revocation or deactivation of Medicare enrollment for certain circumstances such as missed deadlines. The agency intends to withhold payment for services furnished during the "stay of enrollment."

MGMA comment: While MGMA appreciates the introduction of a "stay of enrollment" that would avoid hastily moving to revocation or deactivation for certain violations, we oppose CMS' proposal to not pay for services rendered during the stay. If providers can submit the necessary paperwork during this timeframe to ensure compliance, then they should not be subject to non-payment as this could cause unwarranted billing disruptions.

Behavioral Health

CMS proposal: (88 Fed. Reg. 52361): For 2024, CMS is proposing definitions for Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC) and clarifying that both MFTs and MHCs will now be able to receive payment. Addiction counselors who meet applicable requirements to be MHCs can enroll in Medicare as MHCs. Under this proposal, Health Behavior Assessment and Intervention (HBAI) services could be billed by clinical social workers (CSWs), MFTs, and MHCs, whereas previously

clinical psychologists were the only providers allowed to bill for HBAI. Finally, CMS proposes to implement an increased valuation for timed behavioral health services over four years by applying an adjustment to the work RVUs for psychotherapy codes payable under the PFS.

MGMA comment: MGMA supports CMS' efforts to expand patient access to behavioral health services and urges the agency to finalize its proposals.

Medicare Shared Savings Program (MSSP)

We appreciate CMS' acknowledgement of the impact Accountable Care Organizations (ACOs) and medical groups participating within ACOs have made in providing high-quality, cost-effective care. Many of the changes in this proposed rule build off welcomed adjustments the agency made last year to advance ACO participation. MGMA encourages CMS to continue to institute proposals that effectuate sustained ACO success and allow for more practices to voluntarily join these value-based care arrangements.

Establishing the Medicare CQM

CMS proposal (88 Fed. Reg. 52420): The proposed rule would establish the Medicare Clinical Quality Measures for ACOs participating in the Medicare Shared Savings Program (Medicare CQM) starting in performance year 2024. This new collection type is intended to transition ACOs to report all payer/all patient MIPS CQMs and eCQMs by helping ACOs build the necessary infrastructure and knowledge. The Medicare CQM collection type will focus on Medicare patients with claim encounters with ACO practitioners with specialty designations used in the MSSP assignment methodology. ACOs would still have the option to report quality data using the CMS Web Interface measures, eCQMs, Medicare CQM, and/or MIPS CQMs collection types for performance year 2024, and could utilize eCQMs, MIPS CQMs, and/or Medicare CQMs for 2025.

The agency is proposing to establish the data completeness threshold at 75% for performance years 2024-2026 and 80% for performance year 2027 to align with MIPS data completeness thresholds. CMS would provide ACOs with a list of beneficiaries who are eligible for Medicare CQMs if the ACO requests data for population-based activities in relation to improving health or reducing cost. The agency anticipates sharing the list of beneficiaries once annually at the beginning of the quality data submission period. For performance years 2024 and 2025, CMS is proposing to score Medicare CQMs using performance period benchmarks and will transition to using historical benchmarks in 2026.

MGMA comment: MGMA supports CMS establishing the Medicare CQM for ACOs and appreciates the agency not transitioning to all payer/all patient reporting too rapidly. The agency intends to share the list of beneficiaries once annually at the beginning of the quality data submission period. The introduction of the new Medicare CQM may not allow for ACOs to support reporting this option for performance year 2024 since the final rule is published November. For the initial performance year, CMS should limit reporting to patients provided on the CMS list to ensure greater uptake by ACOs given the complexity and time it will take to identify patients. Reporting under the Medicare CQM option will require ACOs to use considerable resources to ensure patient matching across multiple practices and EHRs.

We still harbor concerns about CMS' proposed transition to all payer/all patient reporting under MIPS CQMs and eCQMs. Requiring ACOs to report all payer/all patient digital measures in the future without significant policy changes is infeasible as ACOs must make changes to operational workflows, secure new technologic capabilities, and familiarize themselves with reconfigured measure sets, all of which require the attention of dedicated staff as well as an upfront financial investment for EHR upgrades.

ACOs often are comprised of multiple group practice TINs that all work in concert to achieve the goals of the ACO, and there may be significant data-sharing limitations that groups will encounter moving to all payer/all patient reporting. There are substantial costs associated with making the technological upgrades needed to report all these measures as well. CMS should provide greater incentives and resources to facilitate the reporting of eCQMs/MIPS CQMs in the future and not require this reporting until the necessary infrastructure is in place.

Similar to the burden imposed by increasing the data completeness threshold for clinicians reporting under MIPS, we want to highlight the problems with raising the completeness threshold to 75% for performance years 2024-2026 and 80% in performance year 2027. Due to the complexities of multiple practices and EHRs involved in a single ACO, it is unrealistic to expect all ACOs to meet this high data threshold. MGMA opposes introducing this data threshold for the Medicare CQM and urges CMS to consider the impact it will have on the operation and coordination of ACOs.

Sunsetting MSSP CEHRT Requirements and Requiring Promoting Interoperability Reporting

CMS proposal (88 Fed. Reg. 52434): CMS aims to streamline CEHRT requirements for ACOs to align with QPP MIPS reporting by sunsetting MSSP's CEHRT threshold requirements so that they apply only through performance year 2023. Currently, ACOs participating in a track that doesn't meet the financial risk standard to be an advanced APM (BASIC track levels A – D) must certify annually that at least 50% of eligible clinicians participating in the ACO use CEHRT. ACOs in a track that meets the financial risk standard to be an advanced APM (BASIC track or the ENHANCED track) must certify annually that 75% of the eligible clinicians participating use CEHRT.

Starting on Jan. 1, 2024, unless otherwise excluded, all MIPS eligible clinicians, QPs and partial QPs participating in an ACO, regardless of track, must satisfy all the following requirements:

- Report the MIPS Promoting Interoperability (PI) performance category measures and requirements to MIPS according to 42 CFR part 414 subpart O as either of the following -
    - All MIPS eligible clinicians, QPs, and partial QPs participating in the ACO as an individual, group, or virtual group; or,
    - The ACO as an entity.
- Earn a MIPS performance category score for the MIPS PI performance category at the individual, group, virtual group, or APM entity level.

A MIPS eligible clinician, QP, partial QP, or ACO may be excluded if they do not exceed the low volume threshold, are an eligible clinician defined at § 414.1305 who is not a MIPS eligible clinician and has opted to voluntarily report measures and activities for MIPS, or has not earned a performance category score for the MIPS PI performance category because the PI category has been reweighted.

MGMA comment: MGMA strongly opposes requiring ACOs to report on the MIPS PI performance category. This proposal does not appropriately facilitate the transition to value-based care, but further hinders participation by requiring additional reporting burdens that may harm ACOs and participating groups beginning in 2024. The final PFS rule is published in November, but ACOs must report to CMS the practices they wish to eliminate from their ACO participation list in September. Therefore, both ACOs and practices — especially smaller ones not utilizing CEHRT — will be forced to report PI and have no other recourse. Compliance will be extremely difficult.

A major benefit of participating in an ACO that qualifies as an advanced APM is the reduced reporting requirements. QPs are excluded from reporting in the MIPS program as established under MACRA, requiring QPs to report the PI performance category contravenes the intention of the statute. "Relief from

MIPS reporting," as one MGMA member phrased it, is a major incentive to join an APM — this proposal undercuts CMS' value-based care goal of having all beneficiaries in an accountable care arrangement by 2030. We urge the agency not to move forward with these burdensome reporting requirements.

Expanded Window for Determining Beneficiary Assignment in MSSP

CMS proposal (88 Fed. Reg. 52443): CMS proposes to add a step three to the step-wise assignment methodology used in MSSP. Beginning in performance year 2025, the agency would include a new step to utilize an expanded window for assignment — a 24-month period that would include the applicable 12-month assignment window and the preceding 12 months. This would account for for beneficiaries who received primary care services from nurse practitioners, physician assistants, and nurse specialists, during the 12-month assignment window and who received at least one primary care service during the expanded window of assignment from a physician. CMS would make corresponding changes to the definition of "assignable beneficiary."

MGMA comment: MGMA appreciates CMS' intention to expand the window for determining beneficiary assignment to better account for beneficiaries receiving primary care from non-physician practitioners (NPPs) and to improve access to care. The proper recognition of NPPs in beneficiary assignment is essential to a well-functioning MSSP. We believe the agency should further study the impacts of this proposal to prevent against any potential unintended consequences. The proposed rule references data from 2021, during the COVID-19 pandemic, and may not necessarily reflect the current environment. We recommend CMS conduct an analysis of these proposed beneficiary assignment changes, especially to underserved populations, to inform future policy making and avoid misattribution issues.

Cap on Regional Risk Score Growth

CMS proposal (88 Fed. Reg. 52456): The proposed rule would modify the regional component of the three-way blended benchmark update factor for agreement periods starting on Jan. 1, 2024. This approach would cap prospective Hierarchical Condition Categories (HCC) risk score growth in an ACO's regional service area between benchmark year three and the performance year using a similar methodology as the one adopted in the 2023 PFS.

MGMA comment: MGMA supports CMS' proposed approach to cap ACO regional risk growth scores. Medical groups in regions with high-risk beneficiaries will now be better incentivized to participate in MSSP. We appreciate CMS' receptiveness to stakeholder concerns and ask for this change to apply to all ACOs.

Risk Adjustment Model Version 28

CMS proposal (88 Fed. Reg. 52479): CMS uses the CMS-HCC risk adjustment model that is applicable for a particular calendar year to identify beneficiaries' prospective HCC risk score for risk adjustment calculations in MSSP. The agency is proposing a policy that would apply the same CMS-HCC risk adjustment model used in the performance year for all benchmark years for agreement period starting on Jan. 1, 2024. CMS finalized the transition to the 2024 CMS-HCC risk adjustment model, Version 28 (v28), on Mar. 31, 2023. V28 will be phased-in over three years — the underlying model will be 67% of the 2020 CMS-HCC risk adjustment model and 33% of the 2020 CMS-HCC risk adjustment model for performance year 2024.

MGMA comment: MGMA supports the phase in of the 2024 risk adjustment model v28 similar to how CMS instituted it for Medicare Advantage. This will soften negative consequences that would result from

a complete and abrupt switch. We support the proposal to use the same risk adjustment model in both performance and benchmark years as this will promote consistent comparisons. The proposed rule discusses the use of separate models and highlights that ACO shared savings payments would have been 11% lower in 2021 with different models. Given the differences between the 2020 and 2024 model —, such as coding changes — we support this change and urge CMS to extend this policy to all ACOs and not just ones entering agreements in 2024 as ACOs were not aware of this change prior to submitting agreements in the summer.

Negative Regional Adjustment

CMS proposal (88 Fed. Reg. 52465): The agency is proposing to mitigate the impact of the negative regional adjustment on the MSSP's benchmarking methodology**.** ACOs that would face a negative overall adjustment to their benchmark under the 2023 PFS methodology would now receive no downward adjustment. Similarly, ACOs that would face a negative regional adjustment amount and are eligible for the prior savings adjustment under the polices adopted in the 2023 PFS would no longer offset the prior savings amount by the negative regional adjustment amount.

MGMA comment: We appreciate CMS' acknowledgement of the detrimental impact these negative regional adjustments may have on ACOs spending higher than their region to treat medically complex patients. ACOs who receive a negative adjustment are more likely to stop participating in MSSP. We support CMS transitioning away from penalizing ACOs that spend the necessary amount to provide high-quality care to the population they treat.

Advance Investment Payments

CMS proposal (88 Fed. Reg. 52483): CMS is proposing changes to its advance investment payment (AIP) policies set to take effect for ACOs entering agreement periods on Jan. 1, 2024. The agency will allow ACOs to advance to two-sided model levels within the BASIC track's glide path beginning in year three of the agreement period they receive an AIP. CMS would only recoup AIPs from the shared savings of an ACO that wishes to renew early instead of directly recouping from the ACO. ACOs that voluntarily terminate their participation agreement to enter into a new participation agreement would not have to immediately repay all AIP**s** after its notice of termination. Further, ACOs receiving AIPs may seek reconsideration review of all payment calculations.

MGMA comment: MGMA reiterates its support for the establishment of AIPs as these upfront investments will help more ACOs participate in the MSSP. Recoupment of AIPs from shared savings instead of a direct recoupment from the ACO may ameliorate some concerns, but these shared savings are vital to encouraging engagement in the ACO. Savings are reinvested by the ACOs, we recommend the recoupment of AIPs over the length of the agreement period as a percentage of shared savings to ensure stability of these new entrant ACOs.

We support CMS' proposed changes to its AIP recoupment policy to not require ACOs to repay all AIPs when they voluntarily terminate their current participation agreement to enter a new participation agreement, but rather have the AIP balance carry over to the new participation agreement period. These changes add needed elasticity to the program to ensure continued participation by new entrant ACOs.

Requests for information

MVP reporting for specialists in MSSP

CMS request for comment: CMS is requesting information about how to facilitate specialists' participation in ACOs in a meaningful way and how to collect quality data that is comparable to data reported by providers in MIPS Value Pathways.

MGMA comment: We caution CMS from moving too aggressively to new MVP reporting requirements in ACO arrangements as 2023 is the first-year clinicians may voluntarily report under an MVP. Given the program is still in its infancy, and as currently constructed repackages many of the problems medical groups experience with MIPS reporting, more data is needed on the program and specialist performance within ACOs. We urge that the agency refrain from proposing additional MVP reporting requirements in ACOs in the future.

Higher Risk Track

CMS request for comment: CMS is seeking comment on incorporating a higher risk track than the ENHANCED track. This new track would offer higher levels of risk and potential savings.

MGMA comment: MGMA appreciates CMS contemplating the inclusion of a higher risk track that would offer increased savings and improved patient care in future rulemaking. This voluntary track could include policies that allow a full risk-option with increased shared savings along with appropriate caps on savings and losses. CMS should work closely with stakeholders to design a new risk track through a transparent and collaborative process to help accomplish the agency's value-based care goals.

Quality Payment Program (QPP)

Merit-based Incentive Payment System (MIPS)

MIPS Final Score and Payment Adjustments

Performance Threshold

CMS proposal (88 Fed. Reg. 52596): The agency proposes to increase the MIPS performance threshold from 75 points in 2023 to 82 points in 2024. This is the result of CMS adjusting its methodology as the agency is proposing to set the MIPS performance threshold by using the mean final scores from the 2017–2019 MIPS performance periods (2019-2021 MIPS payment years).

MGMA comment: MGMA strongly opposes the performance threshold increase from 75 to 82 points. It is an untenable increase based on a methodology predicated on nonrepresentative years of the current healthcare landscape and will severely punish participating clinicians trying to offer high-quality care. While using a three-year mean of previous performance periods may mitigate issues related to yearly aberrations or unreflective scores, by using the 2017-2019 performance periods to calculate the 82-point threshold, CMS is relying on pre-COVID-19 pandemic reporting that occurred in a vastly different MIPS program and care environment.

The 82-point performance threshold will penalize most eligible clinicians as CMS estimates 54.31% of clinicians will receive a negative adjustment. An even greater number of smaller practices will receive negative adjustments with 64.60% of sole practitioners projected to receive a negative adjustment. The agency's estimates are concerning on multiple levels and demonstrate the fundamentally punitive nature of MIPS as currently constructed. Medical groups participating in MIPS must expend significant

resources to comply with program requirements that would be better directed towards patient care. These clinicians provide critical care to Medicare beneficiaries and these negative adjustments do not necessarily reflect care quality, but rather administrative issues.

Many different factors are coalescing to exacerbate issues with the MIPS program such as the lack of an inflationary update and continued cuts to the conversion factor. We urge CMS to work with Congress on a solution while using its enforcement authority to mitigate these consequences as much as possible.

Targeted Review

CMS proposal (88 Fed. Reg. 52601): The agency is proposing to adjust the timeframe for requesting a targeted review from the current policy of 60 days. CMS would open the targeted review submission period once MIPS final scores are released and keep it open for 30 days after payment adjustments are released. CMS states that this would maintain an approximate 60-day review period — 30 days before payment adjustments are released and 30 days after they are released. Additional information requested by CMS must be provided within 15 days of receipt of the request instead of 30 days. Virtual groups and subgroups would be eligible to request a targeted review.

MGMA comment: MGMA opposes shortening the timeframe to 15 days to provide information to CMS as this does not allow enough response time for providers to review and gather the required information. We recommend CMS keep its current policy of 30 days for clinicians to respond to CMS document requests. We appreciate and support CMS' proposal to allow subgroups and virtual groups to request a targeted review.

MIPS Quality Category

Data Completeness Threshold

CMS proposal (88 Fed. Reg. 52565): CMS is proposing a data completeness threshold of 75% for 2026 and 80% for 2027. The agency does not propose changes to the 75% data completeness threshold finalized in last year's PFS for 2024 or 2025.

MGMA comment: We disagree with the proposal to maintain the unnecessarily high data completeness threshold of 75% for 2026 and increasing it further to 80% in 2027. Groups must predict the quality measures to report that are most likely to meet the completeness threshold and this guessing game instills uncertainty in program reporting and adds unnecessary administrative burden. Medical groups with multiple sites of service that bill under one TIN will face technical hurdles meeting this high threshold.

As discussed in previous comments, in lieu of a percentage-based threshold, we recommend using a minimum number of patient policy offers for greater predictability for medical groups. 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 asks 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.

MIPS Promoting Interoperability Category

CMS proposal (88 Fed. Reg. 52546): CMS intends to move away from year-themed "editions" of certification criteria to require that participants meet certification criteria and proposes to revise the

regulatory definition of certified electronic health record technology (CEHRT) to be more flexible and reflect changes from the Office of the National Coordinator for Health Information Technology (ONC).

MGMA comment: MGMA appreciates CMS' intention to promote alignment with ONC's certification criteria by revising its definition of CEHRT. Confusing certification requirements and regulatory definitions can hamper interoperability. Alignment across HHS is necessary to ensure all medical groups, and their EHR vendors are operating under the same understanding. We suggest CMS ensure proper disclosures and plain language be included from EHR vendors to avoid confusion regarding EHR updates so that medical groups remain fully aware of whether the products they are using meet CMS requirements.

180-day Performance Period

CMS proposal (88 Fed. Reg. 52579): CMS proposes to increase the PI performance period to a minimum of 180 days in a calendar year. Under current policy, the performance period is a minimum of 90 continuous days within the calendar year.

MGMA comment: MGMA strongly opposes extending the PI performance period to 180 days. The proposed rule intends to align the MIP PI performance category with the PI program for eligible hospitals and critical access hospitals. We expressed our support for maintaining the 90-day reporting period in previously submitted PFS comments. While we appreciate CMS intention to align these reporting programs, we reinforce the need for CMS to keep program continuity and stability so not to overburden clinicians and medical groups with constantly fluctuating reporting requirements.

Expanding the PI performance period to 180 days will add further pressure to medical group reporting since there is little room for error. Ensuring proper compliance and staff training at the beginning of the year will mean that groups will not be able to adjust to any technical or other problems that occur during the 180-day period. This is in addition to the doubling of reporting requirements by adding an extra three months of reporting burden. We suggest CMS maintain the current 90-day period and work to reduce the onerous PI requirements currently in place.

PDMP Measure Exclusion

CMS proposal (88 Fed. Reg. 52579): For the Query of Prescription Drug Monitoring Program (PDMP) Measure exclusion, the agency is proposing to modify the exclusion as follows: "Does not electronically prescribe any Schedule II opioids or Schedule III or IV drugs during the performance period." This language would replace the second exception for PDMP: "Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period."

MGMA comment: The PDMP measure offers increased patient safety and helps prescribers identify patients who may be misusing prescriptions for controlled substances. CMS finalized the mandatory 10-point measure in the 2023 PFS for the 2023 performance period. CMS believes that the current exclusion language is too broad, and it does not address situations where the MIPS eligible clinician does not electronically prescribe Schedule II opioids or Schedule III and IV drugs, during the performance period, but does write more than 100 permissible prescriptions.

We support this proposal and believe that adding this language is reasonable to encompass situations where clinicians do not electronically prescribe controlled substances and ask for guidance to ensure clarity on how this would apply. As raised in last year's PFS comments, we reiterate that drugs in Schedules III and IV are not clinically appropriate to include in the PDMP Measure and do not to advance the goal of addressing the opioid epidemic.

Clinical decision making regarding the exclusion criteria should solely be in the domain of the eligible clinician. There are circumstances such as chronic illnesses or medical diagnoses such as cancer or patients under care of hospice that should fall under the exclusion criteria as they do not require consultation of the PDMP nor verification of an opioid treatment agreement. These circumstances should be added to the exclusion criteria and could include long-established chronic illnesses or medical diagnoses such as cancer, post-surgical patients, or patients under care of hospice.

SAFER Guide Attestation

CMS proposal (88 Fed. Reg. 52580): The agency is proposing to require a "yes" response for the SAFER Guide measure beginning in the CY 2024 performance period; clinicians will only need to review the High Priority Practices SAFER guide. Previously, clinicians needed to report "yes" or "no" to completing the annual self-assessment.

MGMA comment: MGMA opposes the mandatory attestation of completing the SAFER guide measure and urges the agency to maintain its current proposal while working with ONC and stakeholders to update the guides**.** We appreciate CMS' focus on the safe use of CEHRT as it greatly important for eligible clinicians to identify and mitigate risks to ensure patient safety. However, this new annual requirement will add burden to practices— especially smaller practices that may not have the resources to dedicate to this assessment. Before requiring this self-assessment to be performed by all eligible clinicians, we ask CMS to review the SAFER guides to ensure they are not out of scope for the PI category.

MIPS Cost Category

Cost Improvement Category

CMS proposal (88 Fed. Reg. 52593): The proposed rule would calculate improvement scoring for the cost performance category at the category level without using statistical significance beginning in the 2023 performance year. Under CMS' proposal, the maximum cost improvement of one percentage point would be available in the 2023 performance period, while the maximum cost improvement score will be zero percentage point for the 2022 performance period.

MGMA comment: While MGMA appreciates CMS including a maximum one percentage point cost improvement score for 2023 that can be added to a clinician's score instead of zero percent for 2022, we suggest CMS continue to review how this policy will impact clinicians and work to phase in changes such as increasing the maximum improvement score beyond one point in the future. Due to the cost category being automatically reweighted during the COVID-19 PHE, it will be a few years before yearly cost performance information may be available. The agency should further simplify its cost improvement score calculations to avoid confusion and continue to study how this would work in practice due to this dearth of information.

Episode-Based Cost Measures

CMS proposal (88 Fed. Reg. 52568): The proposed rule includes the following five new episode-based cost measures, each with a 20-episode case minimum, starting in the 2024 performance period: Psychosis and Related Conditions, Depression, Heart Failure, Low Back Pain, and Emergency Medicine. The proposed rule would remove the Simple Pneumonia with Hospitalization measure starting with the 2024 performance period.

MGMA comment: As raised in previous comments, MGMA generally supports the transition to episode-based measures and believes that cost measures should be centered around specific conditions or periods

of care. These cost measures should reflect the group practice model of care where multiple practitioners utilize a team-based approach to treating patients. We urge the agency to ensure that episode-based cost measures are sufficiently reliable and do not double count costs when physicians report the total per capita costs or Medicare spending per beneficiary measures. CMS must provide timely and actionable specifications regarding these measures, particularly as methodologies change year-over-year. We recommend the agency incorporate feedback from physician specialty societies for specific episodes to prevent the establishment of impractical episode-based measures.

Request for Information on Publicly Reporting Cost Measures

CMS request for comment (88 Fed. Reg. 52615): CMS seeks comments on its intention to require public reporting of cost measures for the 2024 performance period. While CMS is required to publicly report MIPS final scores and performance category scores, the agency is authorized but not required to report individual measure activity. The cost performance category is not currently publicly reported.

MGMA comment: MGMA disagrees with publicly reporting cost measures without significant changes due to the lack of currently available information from CMS to clinicians about the cost performance category and our ongoing concerns with how cost measures are evaluated. We question requiring eligible clinicians to publicly report cost measures as currently constructed given the various benchmarking, reliability, and technical concerns about displaying this information coherently for consumers. The agency should conduct further research into how displaying these measures may impact and potentially confuse beneficiaries and incorporate stakeholder feedback.

Underscoring our comments are the continued problems our members see with the cost performance category as it can penalize practices for costs outside of their control. CMS does not provide timely actionable feedback to clinicians on this performance category, and it can have an outsized negative impact on practices due to its opaque nature. Cost measure information was last made available in 2019 before the cost performance category was reweighted to zero in 2020 and 2021 during the COVID-19 PHE.

One MGMA member expressed frustration about a significant decrease to their 2024 MIPS payment adjustment due to the cost performance category in their 2022 performance report. This members' score on two cost measures — Medicare spending per beneficiary and one episode-based cost measure — that applied to 127 out of the 65,000 Medicare beneficiaries the group saw over the performance year caused a drastic decrease in its payment adjustment. Since there is limited available data on the cost performance category, especially comparative information such as the number of procedures a clinician performs to peers, it is hard for practices to understand how they are being evaluated and make the necessary changes. We urge CMS to provide timely actionable data to practices.

We remain concerned with measuring clinicians on the total per capita cost and Medicare spending per beneficiary measures due to these measures penalizing providers by holding them accountable for costs outside of their practices. We urge CMS to revise their flawed attribution and insufficient risk-adjustment methodologies if they continue to utilize these measures.

MIPS Value Pathways (MVPs)

CMS proposal (88 Fed. Reg. 52558): The proposed rule would add the following five MVPs for reporting in CY 2024:

1. Focusing on Women's Health,
2. Quality Care for the Treatment of Ear, Nose, and Throat Disorders,

3. Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV,
4. Quality Care in Mental Health and Substance Use Disorders,
5. Rehabilitative Support for Musculoskeletal Care.

The agency is proposing to combine the Promoting Wellness MVP and Optimizing Chronic Disease Management MVP into the Value in Primary Care MVP.

MGMA comment: MGMA believes CMS should design voluntary MVPs that are clinically relevant and alleviate reporting burden while allowing groups to transition to value-based care. We urge CMS to be cognizant of the infancy of the MVP program, the current lack of specialty MVPs, and reporting problems within MIPS while attempting to develop new MVPs. The agency should work with physician specialty societies in the development of MVPs to better understand opportunities for quality and efficiency improvements and to avoid repackaging issues with MIPS.

Subgroup Reporting

CMS proposal (88 Fed. Reg. 52559): CMS proposes to make numerous changes to subgroup reporting — the agency would not calculate a facility-based score at the subgroup level, subgroups would receive their affiliated group's complex patient bonus if applicable, and subgroups would only receive reweighting based on any reweighting applied to its affiliated group.

MGMA comment: MGMA remains opposed to mandatory subgroup reporting that will be implemented in 2026 as partitioning practices into subgroups could undermine the advantages of the group practice model. The changes in the proposed rule illuminate the difficulty in segmenting multispecialty practices into subgroups as many of the proposed changes illustrate the complexity of these arrangements. We urge CMS to keep subgroup reporting voluntary and not to implement conflicting directives that complicate compliance. Subgroups should have the capacity to receive a complex patient bonus and request reweighting on their own if they voluntarily choose to form one. Subgroups have to submit their composition when registering for an MVP and CMS should be able to identify beneficiaries treated by a subgroup. We oppose these proposals that would prevent subgroups from requesting reweighting and receiving the complex patient bonus.

Advanced Alterative Payment Models (APMs)

Use of Certified Electronic Health Record Technology (CEHRT)

CMS proposal (88 Fed. Reg. 52625): CMS is proposing to remove the requirement that 75% of eligible clinicians participating in an APM entity use CEHRT in order for the APM to be an advanced APM. The agency specifies that in order to be considered an advanced APM, an APM must require the use of CEHRT.

MGMA comment: MGMA recommends that CMS does not modify the current 75% requirement as this will increase reporting burden for APM entities. Smaller practices looking to join APMs that do not possess the current capacity to use CEHRT may be dissuaded as there is no room for APMs to bring them into the fold and help them build the necessary infrastructure. The agency should be encouraging practices not currently using CEHRT to join APM models; by requiring full utilization of CEHRT to be considered an advanced APM without corresponding incentives, glide paths, or other initiatives to promote smaller practices to join, CMS will foreclose another avenue for fostering accountable care growth.

Qualifying APM Participant (QP) Determinations

CMS proposal (88 Fed. Reg. 52617): CMS is proposing to make QP determinations at the individual clinician level only, as opposed to the APM entity level. Most eligible clinicians participating in advanced APMs currently receive their QP determinations at the APM entity level.

MGMA comment: MGMA previously raised concerns with transitioning from QP determinations at the APM entity level to the individual clinician level. While we appreciate CMS' examining how to modify current policies to improve specialist participation in APMs, based on our members' experience, specialists will likely be excluded from participating in advanced APMs if the QP determination is made at the individual level. Many specialists will not individually qualify as a QP or partial QP, while they are more likely to qualify at the APM entity level. This is then further exacerbated by proposed increases to the QP threshold which will make individually qualifying more difficult. Reporting burden will also grow as a result of this proposed change and medical groups will have to adjust their administrative practices to report for each clinician.

MGMA and our member group practices have been longtime champions of a team-based approach to care. We have heard concerns from members about making QP determinations at the individual clinician level instead of at the APM entity level. Here is a sample of responses from members from a recent survey on shifting from the APM entity level to the individual clinician level:

- "Our group would have to adopt more rigid and less variant medical management protocols."
- "We would have to go back to clicking more boxes with each visit in order to report the codes like we did with PQRS. This added time to each patient visit and junked up reports. This is not a good use of MD time."
- "It will add some confusion and administrative redundancy as we will assimilate it internally at the entity level given team-based care approaches of care needed to achieve success in quality improvement and cost reductions."
- "May be best to leave it at the entity level versus individual level. It would seem there will be more administrative complexity for providers at the individual level."

These issues are compounded by that fact that fewer specialty-focused models are being tested by the CMS Innovation Center (CMMI), with a recent MGMA *Stat* poll showing 79% percent of members surveyed said there is not a clinically relevant advanced APM model available to join.[9] Due to this confluence of issues, we urge CMS not to add an additional reporting burden and keep reporting at the APM entity level. If CMS insists on moving forward with this policy, we recommend the agency calculate QP determinations at the APM entity and individual level and apply the more favorable score.

QP and Partial QP Thresholds

CMS proposal (88 Fed. Reg. 52621): Under CMS' proposal, the QP threshold for Medicare payments would increase from 50% to 75%, while the partial QP threshold would increase from 40% to 50% for performance year 2024. The Medicare patients QP threshold would increase from 35% to 50% and the partial QP threshold would increase from 25% to 35% beginning in performance year 2024.

MGMA comment: While we understand the QP and partial QP thresholds are set under 42 CFR § 414.1430, MGMA strongly opposes these significant increases to the QP thresholds beginning in the 2024 performance year. Quality reporting stability is critical to incentivize participation in an advanced

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[9]MGMA Stat poll, July 18, 2023, https://www.mgma.com/mgma-stat/medical-groups-struggle-to-find-clinically-relevant-alternative-payment-models.

APM — aside from being unreasonably high thresholds to meet for clinicians, previously participating clinicians may be unable to remain within an APM due to this drastic change.

We urge CMS to call on Congress to act and allow the agency to set the QP thresholds as reasonable percentages so that clinicians can continue participating in advanced APMs.

APM Incentive Payment

CMS proposal (88 Fed. Reg. 52624): Congress extended the APM incentive payment at 3.5% for the 2023 performance year/2025 payment year. The APM incentive payment had previously been 5% of the clinician's estimated aggregate payments for covered professional services during the 2019-2024 payment years. CMS proposes to end the incentive payments and beginning in the 2024 performance year/2026 payment year. QPs will receive a "qualifying APM conversion factor" of 0.75% of their Medicare PFS update, while non-QPs will receive a 0.25% Medicare PFS update.

MGMA comment: MGMA opposes the expiration of the APM incentive payment as it has had a demonstrably positive effect on allowing practices to transition to value-based care arrangements. Its elimination and shift to the "qualifying APM conversion factor" will likely reduce participation in advanced APM models and cause additional confusion related to the two new conversion factor adjustments to QPs and non-QPs.

One MGMA member recently expressed that the APM incentive payment is the best way to help practices transition into APMs. With the significant financial challenges medical groups continue to experience related to staffing, inflation, and continued Medicare reimbursement cuts, the incentive payment is a lifeline for practices to invest in needed infrastructure and provide high-quality care. Removing this incentive payment and transitioning to the lower conversion factor adjustment will be another barrier towards moving to accountable care arrangements. We urge CMS to work with Congress to extend the original 5% APM incentive payment for at least six years.

Requests for Information on the QPP Program

CMS request for comment (88 Fed. Reg. 52557): CMS is requesting information on transforming the QPP and how they can modify policies to foster clinician's continuous performance improvement and positively impact care outcomes for beneficiaries.

MGMA comment: Numerous policies put forth in this proposed rule — the MIPS performance threshold increase, increasing the QP threshold, the expiration of the APM incentive payment, increasing reporting requirements in ACOs and APMs — are working in concert to slow the transition to value-based care. If these changes are implemented, there will likely be a decrease in clinicians participating in APMs. Longstanding issues within the QPP necessitate a solution so all participating clinicians can succeed. MIPS should remain a viable option for clinicians who cannot transition to a value-based care arrangement, and MVP reporting should remain voluntary. We encourage CMS to adopt more clinically relevant APMs and coordinate with the Physician-Focused Payment Model Technical Advisory Committee (PTAC). To date, none of PTAC's recommended models have been implemented by CMMI.

Several RFI questions relate to reporting requirements, such as: "Should we consider, for example, increasing the reporting requirements or requiring that specific measures are reported once MVPs are mandatory?" MGMA opposes increasing reporting requirements or requiring specific measures to be reported considering the current concerns we have with MIPS and MVPs. The proposed rule acknowledges the increase in reporting burden associated with added measure reporting in the RFI.

MIPS reporting requirements remain one of the most significant regulatory burdens faced by medical groups — according to our 2022 regulatory burden report, 64.56% of practices surveyed found MIPS reporting requirements very or extremely burdensome.[10] A 2019 study found that physicians spent more than 53 hours per year on MIPS-related activities.[11] The researchers concluded that if physicians see an average of 4 patients per hour, then these 53 hours could be used to provide care for an additional 212 patients per year. The same study found MIPS cost practices $12,811 per physician to participate in 2019. We oppose additional reporting burdens in future rulemaking.

The agency asks for possible incentives to join APMs and we would welcome commonsense support for physician practices looking to participate in value-based care arrangements. CMS should provide resources to assist practices with the transition to APMs, technical guidance to practices looking to join an APM, and work with Congress to extend the APM incentive bonus at 5%.

In addition to our recommendations in this comment, we urge CMS to work with Congress to pass legislation that would institute structural reforms to allow for a stable and functioning QPP. MGMA submitted a letter for the record to Congress earlier this summer about policies that would help reform MACRA.[12] Such policies include implementing an annual inflation-based physician payment updates based on the MEI, opposing the use of sequestration and PAYGO rules to offset unrelated congressional spending, and addressing the budget neutrality component of Medicare that leads to perverse and harmful policies.

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 Claire Ernst, Director of Government Affairs, at cernst@mgma.org or 202.293.3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs

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[10] MGMA Regulatory Burden Report, Oct. 2022, https://www.mgma.com/getkaiasset/b7e88b99-8e93-44a9-8144-725ca956089e/10.11.2022-MGMA-Regulatory-Burden-Report-FINAL.pdf.

[11] Dhruv Khullar, Amelia Bond, and Eloise May O'Donnell, *Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System,* JAMA Network, May 2021, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947.

[12] MGMA, Testimony - MACRA Checkup: Assessing Implementation and Challenges that Remain for Patients and Doctors, June 22, 2023, https://www.mgma.com/getkaiasset/ad67de75-a3a1-4386-b683-d0e34e93a8fa/06.22.2023_MGMA%20Letter%20for%20the%20Record%20-%20MACRA%20hrg.pdf.