Nov. 17, 2015

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-3321-NC: Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

Dear Administrator Slavitt:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the Request for Information entitled, "Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models" released on Oct. 1, 2015 with file code CMS-3321-NC. We look forward to working with the Centers for Medicare & Medicaid Services (CMS) to develop the framework of the Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs).

MGMA helps create successful medical practices that deliver the highest-quality patient care. As the leading association for medical practice administrators and executives since 1926, MGMA helps improve members' practices and produces some of the most credible and robust medical practice economic data and data solutions in the industry. Through its national membership and 50 state affiliates, MGMA represents more than 33,000 medical practice administrators and executives in practices of all sizes, types, structures and specialties in which more than 280,000 physicians practice.

Introduction

In the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which repealed the sustainable growth rate formula, Congress recognized the significant regulatory burdens placed on physicians and group practices under Medicare's increasingly complex and unsustainable quality reporting programs. As such, MACRA instructed CMS to consolidate PQRS, the valuebased payment modifier (VBPM), and the EHR Incentive "Meaningful Use" Program into the new MIPS. While MGMA is pleased to work with CMS to develop a harmonized MIPS program, we are concerned with the over-reliance of this RFI on the existing flawed programs. The intent behind MACRA was to hit the reset the button on these programs; yet the volume of detailed and presumptive questions raised in this RFI indicates that the agency may already be overlooking a critical opportunity to eliminate the myriad of duplicative reporting requirements. Overall, the tone of this RFI signals that CMS is looking backward instead of forward.

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MGMA strongly urges CMS to fundamentally simplify how it currently measures and evaluates cost and quality rather than building MIPS upon the collapsing foundation of Meaningful Use, PQRS, and the VBPM. We view this RFI as the starting point of a much larger dialogue with physician practices. Only with an ongoing dialogue with clinical experts and physician groups will we truly be able to answer these questions.

In principle, MGMA believes that the MIPS and APM programs should meet a standard of core objectives in order to move the new payment system forward and empower groups and providers to innovate new processes of care. We worked closely with the physician community to develop consensus on a core set of principles, and we ultimately believe the framework of MIPS and APMs should:

- **Support delivery system improvements.** Constraints and limitations of current payment systems that only obstruct physician-identified care improvements must be eliminated. In addition, requirements for new models should be flexible enough to support different organizational arrangements and patient population needs so that innovation can truly flourish.
- **Avoid administrative and cost burdens for patients.** Patients should not be unduly burdened with hidden costs, administrative requirements or other obstacles that discourage them from seeking care or fulfilling treatment plans.
- **Reduce administrative burdens for physicians.** Administrative burdens must be limited and reporting tasks streamlined so that the delivery of patient-centered care is the principal focus in all clinical settings.
- **Improve current quality measurement and reporting systems.** Medicare's existing quality measurement and reporting programs cannot and should not simply be combined to form the MIPS program. These currently separate programs must be carefully assessed, revised, aligned, and streamlined into a coherent, flexible system that is truly relevant to high-value care. In particular, the regulatory framework for EHR systems under the Meaningful Use program must be revised to eliminate obstacles to technological innovation, enable interoperability and improve usability to meet the needs of patient care and reduce the burden of excessive data collection requirements on physician practices.
- **Recognize patient diversity.** Risk adjustment for patient characteristics related to health status, stage of disease, genetic factors, local demographics and socioeconomic status must be reflected in performance assessments to accommodate variations in patient need and cost of care and to ensure broad access to high-value care**.**
- **Provide a choice of payment models.** Physicians in all specialties, practice settings, and geographic areas should have the opportunity to choose from the payment models available, based on what best accommodates their practice and the needs of their patients**.**
- **Be equitable.** No specialty or payment model should put forth disproportionate resources in order to succeed, nor should any specialty experience hardship because insufficient resources have been devoted to develop quality measures or other delivery model components that are relevant to their patients and scope of care**.**

- **Be relevant and actionable.** Physicians should be held accountable only for the aspects of cost and quality that they can reasonably influence or control. Patient attribution methods must reflect these concerns. Timelines and deadlines must be realistic, significant policy changes should be phased-in, and feedback on individual performance and benchmarks must be accurate, timely and actionable.
- **Provide stability and educational resources.** Payment systems must provide adequate and predictable resources, and ensure that physicians have access to tools they will need to redesign their practices to support the delivery of high-value care to all patients.
- **Be transparent.** Performance expectations and assessment methodologies must be valid, clinically relevant, scientifically tested, and transparent so that physicians have access to timely, accurate and actionable data for managing patient care. Medicare must provide claims and other performance data to physicians on the patient population covered by the delivery and payment model used in their practice.

Merit-Based Incentive Payment System (MIPS)

MIPS Identifier and Exclusions

CMS: *Should we use a MIPS eligible professional's (EP's) taxpayer identification number (TIN), national provider identifier (NPI), or a combination thereof?*

Because success in MIPS will require a concerted effort at the group practice level to develop a robust health information technology infrastructure, demonstrate clinical practice improvement, and identify and reduce potentially wasteful resource use, CMS should evaluate MIPS performance and apply a MIPS payment increase or decrease at the group practice level. MGMA believes that CMS should utilize a group practice's existing TIN as its principal MIPS identifier. MGMA is concerned that applying a MIPS payment increase or decrease at the individual level would undercut a practice's ability to manage the impact of MIPS and create a chaotic scenario in which every physician and practitioner in a group is subject to different Medicare conversion factors, which will be further complicated anytime a provider switches practices. MIPS should support and encourage the group practice model.

CMS: *Should we create a distinct MIPS identifier? What are the advantages and disadvantages associated with creating a distinct MIPS identifier?*

MGMA discourages CMS from creating a new MIPS identifier. Requiring groups and providers to familiarize themselves with and register under a new identifier in addition to navigating the changes under this new payment system would pose an unnecessary burden at a time of major transition. In addition, it is not clear that CMS would be able to administer payments or penalties sufficiently through a new identifier separate from a TIN and whether the identifier would require modifications to the 1500 claim form.

CMS: *What safeguards should be in place to ensure that MIPS EPs do not switch identifiers if they are considered "poor-performing?"*

Applying the MIPS payment adjustment at the TIN level will achieve CMS' aim of closing potential loopholes through which EPs may avoid a MIPS payment reduction by switching identifiers. Although obtaining a new unique MIPS identifier would likely be administratively burdensome and challenging, it is unlikely to be as expensive and time-intensive as dissolving an existing TIN and creating a new one, which among other things, typically requires a group to

renegotiate its payer contracts. As a result, tying MIPS to a group practice's existing TIN not only serves to eliminate unnecessary hurdles associated with establishing and obtaining a new identifier, but also reduces the likelihood that EPs will elude MIPS payment reductions by switching identifiers.

CMS: *Should a different identifier be used to reflect eligibility, participation, or performance as a group practice vs. as an individual MIPS EP? If so, should CMS use an existing identifier or create a distinct identifier?*

While CMS should evaluate MIPS performance at the group practice level and apply MIPS payment increases or reductions to providers billing under the group's TIN, the agency should permit individual practitioners or subsets of EPs in the group to report, attest, or otherwise document their quality, resource use, meaningful use of EHR, and clinical practice improvement activity data. CMS should welcome a variety of measures and reporting vehicles to ensure the agency is fully capturing a group practice's MIPS narrative, particularly for multi-specialty groups and in the event that the same measures or reporting options may not be relevant to all of the providers within the group. We emphasize that these important internal reporting decisions need to be left to the group practice and its practitioners, not handed down from CMS.

CMS: *What safeguards should be in place to ensure that we are appropriately assessing MIPS EPs and exempting only those EPs that are not eligible for MIPS?*

Under MACRA, providers who are new to Medicare, providers who participate in qualifying APMs, or providers who meet a to-be-determined low-level threshold of Medicare claims (which may be based on a minimum number of individuals enrolled, items and services furnished, or allowed charges billed) will be exempt from participating in the MIPS program. CMS needs to ensure that providers know where they fall in relation to the low-volume threshold or their approved APM status before it is too late for them to participate in MIPS. The consequences of not informing providers of their MIPS eligibility and APM qualification will result in medical groups receiving unfavorable assessments that carry heavy penalties if it is discovered at the end of a performance year that they should have participated in MIPS. This information needs to be clearly and accurately communicated to groups and providers as close to the start of a performance year as possible.

Virtual Groups

CMS: *Should there be a maximum or a minimum size for virtual groups? Should there be limitations, such as that MIPS EPs electing a virtual group must be located within a specific 50mile radius or within close proximity of each other and be part of the same specialty? Should there be a limit placed on the number of virtual group elections that can be made for a particular performance period for a year as this provision is rolled out? Should we limit for virtual groups the mechanisms by which data can be reported under the quality performance category to specific methods such as a qualified clinical data registry or utilizing the group's web interface?*

The complexities and potential consequences of this largely untested and undefined mechanism cannot be identified through the technicalities raised in this RFI. In general, MGMA urges CMS to consider the flexibility afforded by MACRA under Section 1848(q)(5)(I)(ii), in which a virtual group **may** be based on appropriate classifications of providers, such as by specialty designations or geographic areas. However, as CMS works to implement the virtual group option, MGMA

strongly encourages the agency to first work with the provider community to establish a framework for the virtual group option. Imposing limits on size, reporting mechanism, specialty designation, geography, or eligible participants who may convene a virtual group is not the same as defining this reporting option. In addition, the lack of framework raises the risk of potential compliance and anti-trust issues.

CMS also needs to inform the provider community of the specific issues the agency faces in implementing this option. We encourage the agency to take a more active role in this dialogue so that stakeholders can work with CMS to mold the virtual group option into a viable reporting method.

Quality Performance Category: Reporting Mechanisms Available for Quality Performance

CMS: *Should we maintain all PQRS reporting mechanisms noted above under MIPS?*

CMS needs to take advantage of the opportunity to fix what is not working in the current quality reporting programs. At the same time, the initial transition to MIPS needs to be as seamless and non-disruptive to clinical practice as possible. At a minimum, CMS should maintain all of the current PQRS reporting mechanisms to ensure flexibility for providers and groups that have different resource capabilities, and to provide continuity as practices transition to MIPS.

CMS: *Should we maintain the same or similar reporting criteria under MIPS as under the PQRS? What is the appropriate number of measures on which a MIPS EP's performance should be based? Should we maintain the policy that measures cover a specified number of National Quality Strategy (NQS) domains?*

MGMA strongly advises CMS to eliminate the reporting burdens that exist under PQRS when establishing the MIPS quality performance category. Under the current PQRS program, providers and groups must report nine measures across three NQS domains. Continuing to require that groups complete 100% of the work that is currently needed to be successful in PQRS under the MIPS program where quality measures will only account for 30% of the composite score will essentially triple the administrative burden and continue the tradition of reporting for reporting's sake. Furthermore, CMS does not have adequate evidence to justify maintaining the current level of required measures. There is no sound reason to continue these requirements under MIPS when it has been clear that many groups and providers struggle to meet current program requirements.

Instead, CMS should reduce the reporting requirement to the standard of three measures and allow EPs and group practices to report additional quality measures at their discretion. Additionally, requiring a base level of NQS domains to be reported presents an unnecessary challenge for groups and EPs, particularly specialty providers, to find enough relevant clinical quality measures that also fit into an artificially-constructed domain.

CMS: *Should we require that certain types of measures be reported? For example, should a minimum number of measures be outcomes-based?*

Providers and groups should have maximum flexibility to choose measures. MGMA opposes a minimum threshold for outcomes measures, as we are concerned that it may preclude some specialties from meeting program requirements due to small sample sizes and difficulty demonstrating how providers contributed to a required outcome. In addition, existing patient attribution and risk adjustment methodologies remain unreliable, which unfairly prevents groups and providers from demonstrating genuine clinical successes.

CMS should consult with physician specialties to determine which providers are able to report certain types of measures, including potentially evidence-based process measures that demonstrably lead to improved outcomes. In cases where there are no applicable measures, physician specialties can work with CMS to determine alternative measure options.

CMS: *What are the potential barriers to successfully meeting the MIPS quality performance category?*

First and foremost, CMS should reduce administrative complexities in reporting quality data, particularly reporting through multiple portals, undiscernible feedback reports, the uncertainty of who is eligible to report and for how many patients, and the challenges in finding clinicallyrelevant quality measures that also fit into artificially constructed quality domains. These complexities are overwhelming, discourage EPs from reporting, and ultimately detract from patient care. MIPS should not carry on the tradition of flawed quality and cost assessments under a different name. We remind CMS that the intent behind creating MIPS is to hit the reset button and put an end to the broken elements of current quality programs in order to create a truly consolidated and workable program.

In addition, CMS must continue to address measurement gaps and improve the existing set of measures. MGMA is concerned that CMS has not yet allocated MACRA-authorized funding toward this effort, and we urge the agency to do so as expeditiously as possible considering the first MIPS performance year may begin in 2017. Congress allocated funding because it is widely recognized that the current lack of clinically relevant and statistically valid quality measures is a significant hindrance to quality improvement efforts and will remain one of the greatest barriers to success in the MIPS program if unaddressed. We urge CMS to immediately fund measure development in order to close the gap in available measures for certain specialties and conditions, to work with the appropriate bodies to identify insufficiencies in the current measure list, and fill the identified gaps in an ongoing, transparent manner.

Data Accuracy

CMS: *What should CMS require in terms of testing the qualified registry, qualified clinical data registry, or direct EHR product, or EHR data submission vendor product? How can data be enhanced to improve data integrity?*

MGMA agrees that data accuracy should be the foundation of any quality reporting program. Ensuring that data inaccuracies are avoided from the outset will ensure the MIPS program begins on the right foot. However, MACRA does not explicitly outline any new data integrity requirements for MIPS; thus, when addressing this data accuracy concern, we encourage CMS to balance the need for data integrity standards with sensible policies that foster physician trust in the system while eliminating undue administrative burdens. We encourage CMS to work with

vendors, specialty societies, registries, and other stakeholders to strengthen data submission standards and safeguard against passing costs or burdens to practices.

CMS: *If CMS determines that the MIPS EP (participating as an individual EP or as part of a group practice or virtual group) has used a reporting mechanism that does not meet our data integrity standards, how should CMS assess the MIPS EP when calculating their quality performance category performance score? What consequences should there be for MIPS EPs?*

Given the recently discovered 2014 PQRS data submission inaccuracies submitted by Qualified Clinical Data Registries (QCDRs) and EHRs, it is clear that CMS has not adequately ensured that data integrity standards exist in the current quality reporting programs. The application and vetting season for qualified entities presented an opportunity to identify weaknesses in data integrity standards and for vendors to communicate any challenges in meeting data submission format requirements. Instead, as the errors were not discovered until late 2015, CMS has announced that it will classify all affected groups and providers as having provided "average quality, average cost" healthcare for the 2016 payment year. Unfortunately, groups and EPs that provided high quality care at lower costs will miss the opportunity to earn an upward adjustment as a result of subpar vendor data integrity standards, even though these issues were not under practices' control.

Under the MIPS program, more groups and EPs will likely choose to report via a QCDR or EHR, as MACRA encourages groups and providers to utilize them. Therefore, we urge the agency to be proactive and not reactive in communicating submission problems to both vendors and practices during a performance year, and allow medical groups and providers the opportunity to resubmit and correct data within a reasonable timeframe in the case of any submission problems. CMS's policy of holding groups harmless from penalties and considering them to have provided "average quality, average cost" healthcare should be a secondary policy, not the first and only option. Vendors should also be forthright if they are unable to meet data submission standards so that groups and providers can find an alternative means to report MIPS data. We urge CMS to find solutions to keep medical practices from being held accountable for vendors' mistakes.

Use of Certified EHR Technology (CEHRT) under the Quality Performance Category

CMS: *Under the MIPS, what should constitute use of CEHRT for purposes of reporting quality data? Instead of requiring that the EHR be utilized to transmit the data, should it be sufficient to use the EHR to capture and/or calculate the quality data? What standards should apply for data capture and transmission?*

Using any effective method of electronic capture and transmission of quality data should satisfy the requirement that an EP employ an "interoperable" system. In particular, CMS should not require that CEHRT use the HL7 Quality Reporting Document Architecture (QRDA) for capturing and transmitting data. Further, transmission of quality data using XML should be permitted. Requiring CEHRT and QCDRs to only use QRDA will require significant time and resources for vendors to deploy and physician practices to implement. Thus it is imperative that sufficient time be provided for the industry to adopt this approach.

MGMA contends that there should be a base-level standard required by all health IT systems (including QCDRs) for submitting or accepting CQM data. Both QCDR XML and QRDA

category III standards are currently permitted for PQRS reporting. However, for those EPs participating in both PQRS and Meaningful Use, only the QRDA format is accepted by CMS for reporting. While both QCDR and QRDA formats are represented in XML, 2015 Edition Certification requires that all health IT modules used for the submission of CQM data must be certified to the QRDA (I & III) format. As QRDA is already required for Meaningful Use and PQRS reporting, and 2015 Edition Certification also requires QRDA I & III, we believe the industry is best served at this point by identifying QRDA as the reporting standard. However, we urge the Administration to work with industry stakeholders to develop a glide path to migrate health IT products over to a more flexible data reporting format in the future.

Finally, MGMA recommends that medical groups receive credit for the MIPS Meaningful Use option when reporting quality measures electronically to CMS through either registry or EHR reporting. In addition, any approved quality measure reported using this approach should count for full Meaningful Use credit, not merely the electronic clinical quality measure component, as is currently the case.

Resource Use Performance Category

CMS: *Currently under the VBPM, we use the following cost measures: 1) total per capita costs for all attributed beneficiaries measures, total per capita costs for beneficiaries with specific conditions (diabetes, coronary artery disease, chronic obstructive pulmonary disease, heart failure), and Medicare spending per beneficiary. What role should episode-based costs play in calculating resource use and/or providing feedback reports to MIPS EPs under Section 1848(q)(12) of the Act?*

Under this RFI, CMS implies its intention to essentially continue and expand the VBPM's current cost measures under MIPS. MGMA vehemently opposes this approach. Current VBPM measures are irrelevant for many physicians, either because they have no patients attributed to them, or because they have little opportunity to influence costs. CMS needs to conduct rigorous data analysis to replace the flawed VBPM methodology with improved episode-based measures, attribution policies that accurately illustrate the patient-provider relationship, and risk adjustment methodologies that do not penalize or discourage providers from treating atypical or chronicallyill populations. The agency should only consider adopting measures that have a solid evidence base and are developed through a multi-specialty, clinician-led process. Transparency and physician involvement in developing these measures and accompanying methodologies are especially critical.

CMS: *How should we apply the resource use category to MIPS EPs for whom there may not be applicable resource use categories?*

CMS should consult with the specialties whose providers are most likely to experience this shortage in order to determine how best to redistribute the available points in this category. There may be an opportunity to redistribute weight to other MIPS categories or create alternative measures for providers who have no applicable measures in this category.

Clinical Practice Improvement Activities

CMS must define clinical practice improvement activities in the broadest terms possible. This category should not be created as another mechanism that prioritizes reporting over patient care. Rather, medical groups and providers must be given the discretion to participate in activities that best suit their unique practice and specialty needs. Many medical groups already engage in a number of activities that promote and improve the quality and efficiency of care that would be considered subcategories within the clinical practice improvement category. We encourage CMS to work with the provider community to structure this category as a feasible instrument of practice improvement efforts with appropriate flexibility to capture, not hamper, these ongoing efforts.

CMS: *Should EPs be required to attest directly to CMS through a registration system, web portal, or other means that they have met the required activities and to specify which activities on the list they have met? Or alternatively, should qualified registries, QCDRs, EHRs, or other health IT systems be able to transmit results of the activities to CMS? How often should providers report or attest that they have met the required activities?*

Physicians should have the opportunity to demonstrate their performance on clinical practice improvement activities through as simple and flexible a process as possible and through a variety of available mechanisms that best fit the group's unique capabilities. Transmission of clinical practice improvement activities should be permitted but not required through electronic health records and QCDRs when and where capabilities exist, but this should not be a requirement for success. We believe that, at the outset, no more than annual attestation may be the best option. We encourage CMS to employ the least burdensome methodology as it further develops this performance category.

CMS: *What threshold or quantity of activities should be established under the clinical practice improvement activities performance category? Should the threshold or quantity of activities increase over time?*

Clinical practice improvement activities should be based on either completion or ongoing participation in a specified activity or number of activities rather than hours devoted. Group practices and providers, not CMS, should determine what clinical practice improvement activities to report and how these are quantified. Significant stakeholder involvement is needed to define eligible activities within a widely-understood framework of this category. CMS should involve stakeholders in this process before attempting to define this category based on reporting requirements.

CMS: *How should we define the subcategory of participation in an APM?*

The definition of the APM subcategory under MIPS should not be limited to qualified APMs as defined under MACRA, but should incorporate participation in any APM including those sponsored by a commercial payer, state government agency, or Medicaid. MGMA believes that group practices that participate in an APM should receive full credit for the clinical practice improvement category.

CMS: *For the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS reporting option specifically, should this still be considered as part of the quality performance*

category or as part of the clinical practice improvement activities category? What considerations should be made as we further implement CAHPS for all practice sizes?

CMS should allow the CAHPS for PQRS survey to be optional under the clinical practice improvement activity category. We do not believe that patient experience and patient satisfaction should be considered quality metrics, as factors included in surveys are often outside a physician's control. Patient satisfaction is important; however, it does not always translate to better clinical outcomes.

Meaningful Use of Certified EHR Technology (CEHRT) Performance Category

Meaningful Use has already been named as one of the four components of MIPS. That said, by sunsetting the current Meaningful Use Program, Congress has signaled that it wants the Administration to reformulate the program prior to its inclusion in MIPS. While Stage 1 of Meaningful Use accelerated adoption of EHR technology (with now approximately 75% of clinicians using EHRs compared to just 18% prior to the start of the program), Stage 2 has proven exceedingly difficult for EPs to meet with just 12% of EPs to date having attested to meeting the more rigorous Stage 2 requirements. Rather than move ahead with an ill-conceived third stage, we strongly urge CMS to hit pause on the program and seriously reevaluate and redesign the Meaningful Use component of MIPS for 2019.

MGMA and numerous other stakeholders have urged the Administration to take a different path to achieving the vision originally laid out by Congress in the American Recovery and Reinvestment Act. The program should focus on promoting interoperability and allowing innovation to flourish as vendors respond to the demands of physicians and hospitals, rather than the current system where vendors channel all of their energy toward meeting ill-informed checkthe-box requirements. Despite all this, the Administration recently issued misguided Stage 3 requirements that only perpetuate failings of the current program.

With the premature release of the Stage 3 final rule, we are concerned that CMS has imposed a regulation that will lead to widespread EP failure. Rather than build on the modest improvements made to Stage 2, the agency has reverted back to the same fundamental flaws in the previous stage of the program by focusing heavily on increased measure thresholds and excessive documentation. The focus needs to be on what clinicians really need, improving interoperability and usability. CMS will only guarantee continued failure should Stage 3, as it is currently written, be incorporated into MIPS.

It is absolutely critical that the MIPS Meaningful Use component be crafted in such a way that encourages clinicians, especially specialty physicians and those practicing in smaller and rural settings, to adopt these important technologies and meet program requirements, and does not inhibit them from doing so with unachievable measures and thresholds. With a significant percentage of private practice EPs still not participating in the EHR Incentive Program, we remain concerned that simply requiring the current Stage 3 requirements for MIPS will actively discourage clinicians from acquiring and using EHR technology in a "meaningful" way.

MGMA general recommendations on the Meaningful Use Program

As the Meaningful Use component of MIPS is developed, we urge the Administration to consider the following general principles:

- Apply Meaningful Use at the TIN or group practice level.
- Assess all measures to determine:
  - Relevance to all specialties and the conditions they treat;
  - Cost-benefit implications, including the cost of lost clinician productivity; and
  - Whether actions are controlled by the physician and not by patients, technology, or other factors over which providers have little or no influence.
- Ensure that measure thresholds are reasonable and achievable.
- Establish reporting periods of 90 or fewer consecutive days.
- Avoid requiring actions of patients or third parties to meet program requirements.
- Focus on achieving interoperability.
- Encourage improvements in software usability.
- Work directly with physician specialty societies and other key stakeholders to develop appropriate measures and thresholds.

CMS: *Should the performance score for this category be based solely on full achievement of Meaningful Use? For example, an EP might receive full credit (for example, 100 percent of the allotted 25 percentage points of the composite performance score) under this performance category for meeting or exceeding the thresholds of all Meaningful Use objectives and measures; however, failing to meet or exceed all objectives and measures would result in the EP receiving no credit (for example, zero percent of the allotted 25 percentage points of the composite performance score) for this performance category. We seek comment on this approach to scoring.*

To date, Meaningful Use has been developed in such a way that an EP can fail one minor component, and consequently fail the entire program for that reporting year, missing out on an incentive payment and falling subject to penalties. With MIPS, CMS has the opportunity to redesign Meaningful Use to permit a more flexible approach for group practices. We contend that the current "all or nothing" method be replaced with a scalable approach that would provide a practice a score for partially meeting the requirements. Should a group practice fail to satisfy an individual measure, and not meet the prerequisites of any available exclusion from the failed measure, it should only lose a smaller, proportional percentage—not the full 25%. Similarly, each measure requirement itself should have a tiered approach to avoid having providers score a zero on a measure when they could have been 99% successful in meeting a threshold (i.e., electronic prescribing).

CMS: *Should CMS use a tiered methodology for determining levels of achievement in this performance category that would allow EPs to receive a higher or lower score based on their performance relative to the thresholds established in the Medicare EHR Incentive Program's Meaningful Use objectives and measures? For example, an EP who scores significantly higher than the threshold and higher than their peer group might receive a higher score than the median performer. How should such a methodology be developed? Should scoring in this category be based on an EP's under- or over-performance relative to the required thresholds of the objectives and measures, or should the scoring methodology of this category be based on an EP's performance relative to the performance of his or her peers?*

In general, medical groups should be given considerable flexibility when participating in these programs. MGMA recommends that performance tiers be utilized only for research and educational purposes, not for MIPS scoring. Due to significant variability between medical specialties, practices should not be judged on an arbitrary performance benchmark unless that benchmark is appropriately specialty and subspecialty-specific risk-adjusted. Is the practice in an area where fewer pharmacies accept e-prescriptions? Are physicians treating patient populations that have less access to the Internet? These factors and others could significantly impact a practice's ability to score higher on a measure scale relative to their peers. Using a performancebased/tiered methodology for the Meaningful Use component of the composite score could unfairly penalize medical groups based on circumstances largely outside their control—such as subspecialty/scope of practice, location/setting, health information exchange network availability, business environment/competition, and patient population, among others.

CMS: *How should hardship exemptions be treated?*

Group practices that successfully apply for a hardship exception should receive the full 25% score allotted to this category. MGMA also supports a MIPS hardship exception category for practices that have switched from one CEHRT product to another or who have had their CEHRT decertified. As it is a costly and time-consuming process to move from one EHR product to another, we recommend the exception apply for a minimum of three years.

Concerning the lack of available internet access exception, we recommend CMS publish a definitive explanation of what constitutes "limited access" and provide links to a list of all counties that have been identified by the Federal Communications Commission or another agency as having limited internet access. MGMA also supports expanded hardship exceptions for practices that experience unforeseen circumstances that make it impossible to demonstrate Meaningful Use requirements through no fault of their own and encourage expanding this exception to five years after they begin experiencing said unforeseen circumstances.

While we appreciate that a number of medical specialties (Anesthesiology, Radiology, and Pathology) have been granted an exception due to the fact that they typically do not have face-toface encounters with patients, we do not believe these exemptions should be time-limited. We contend that should a practice qualify for this "specialty exception," it is because they do not have the ability to participate in Meaningful Use based on current specialty-specific technological capabilities and program requirements, which will not change over time.

In addition, we recommend that once a hardship application has been submitted, applicants receive an immediate email receipt confirmation. This would avoid the situation that some of our members have encountered, where they find out after the hardship exception deadline has passed that the application was not officially received. Similarly, we recommend that an applicant receive an email confirmation of acceptance or denial of the hardship exception as soon as it becomes available.

Finally, hardship "exclusions" should also be considered. This would replicate what CMS established in FAQ 12775, where the agency permitted an EP to apply for an alternate exclusion for public health reporting. This "exclusion" approach is not in lieu of exceptions, but rather should be offered to practices that experience challenges (typically software-related) in meeting

one or more of the program requirements so that they are still able to participate in the program as a whole.

Development of Performance Standards

CMS: *Which specific historical standards should be used?*

Although MACRA requires CMS to **consider** historical performance standards, it stops short of requiring the agency to actually **use** historical standards. Given the imperfect and still-changing nature of the current programs, it is preferable to use some future year as the basis for determining what constitutes "historical" performance. The legislative intent is not to base this future program on current, flawed program standards, since a large percentage of physicians will have VBPM scores that are not based on actual data and others will have scores that bear little relevance to their own performance. Consequently, the VBPM would serve as an ill-conceived foundation for performance under MIPS. CMS should consult with medical organizations to identify potential sources of data, including QCDRs, for alternative historical performance standards.

CMS: *How should we define improvement and the opportunity for continued improvement? How should CMS incorporate improvement in the scoring system or design an improvement formula? What should be the threshold(s) for measuring improvement?*

MIPS is not designed to be a tournament-style program, as CMS is required to disclose benchmarks prior to the start of a performance period. Abundant education and outreach regarding performance standards and scoring is paramount to success of the program, so that groups and providers know exactly what standards they are expected to achieve.

Improvement may be defined on a yearly basis; however, CMS should not introduce methodologies that are untested or at least not without significant education to ensure providers trust in the scoring system.

CMS: *Should CMS use the same approach for assessing improvement as is used for the Hospital Value-Based Purchasing Program? What are the advantages and disadvantages of this approach?*

The Hospital Value-Based Purchasing Program awards participants with points for improvement compared to an established baseline and additional points for achievement as compared to performance from the prior year. This may work in the hospital environment; however, there are thousands of group practices operating in a fluid environment of recruitment, acquisition, expansion, and reduction. The current two-year gap between performance and payment years makes it extremely difficult to gauge improvement.

Feedback Reports

CMS: *What types of information should we provide to EPs about their practice's performance within the feedback report? For example, what level of detail on performance within the performance categories will be beneficial to practices?*

CMS must be forthcoming in feedback reports regarding the methodologies used to comprise benchmarks or attribute patients for a particular measure. This information must be clearly identified and easy to interpret. Current feedback reports lack key details that are necessary to understand the methodologies used to arrive at benchmarks and other calculations. This creates frustration and distrust among practices about the nature of how these determinations are made, and must be avoided going forward if CMS wants to create a program grounded in legitimacy and transparency.

Where appropriate, CMS should aim to display feedback and performance measurement information graphically with additional details displayed elsewhere. CMS should bear in mind that the purpose of these reports is to allow practices to estimate their current performance and to demonstrate potential areas of improvement. The agency should design these reports accordingly with specific, actionable information. Detailed information should be provided in feedback reports, including the ability to see practice-level, high-level, overall performance information, and drill-down information on physicians as associated with individual patient information.

CMS: *What other mechanisms should be leveraged to make feedback reports available? Currently, CMS provides feedback reports for the PQRS, VBPM, and the Physician Feedback Program through a web-based portal. Should CMS continue to make feedback reports available through this portal?*

With technology constantly changing, it is critical that CMS take an ongoing approach to improving the way performance information is disseminated to physicians and practices. Stakeholder input should be solicited throughout this process to ensure that feedback is provided in a format that works best for physicians and is meaningful to their practice's ongoing improvement activities. These reports should also be provided in a variety of mediums, including but not limited to web-based reports, as well as dashboards and paper reports.

CMS: *Who within the EP's practice should be able to access the reports?*

To improve overall efficiency and actionability, feedback reports should be accessible to physicians, practice administrators or other individuals delegated by the physician. It is important for physician group practices to have access to overall organization performance feedback in order to drive quality improvement.

The log-in process for accessing reports must be simple and user-friendly. There have been ongoing problems with accessing reports due to the overly complicated log-in process and cumbersome password requirements which reset at very short intervals, and ultimately limit access to these reports. CMS staff, not just contractor staff, should also be more accessible to help physicians and administrators access and interpret these reports.

CMS: *With what frequency is it beneficial for an EP to receive feedback?*

CMS must provide ongoing, real-time feedback on performance and should regularly consult with stakeholder groups to determine the best presentation and format for sharing performance feedback information with physicians and practices. In addition, effective education does not

include sending the same resources multiple times per day or week. MGMA has consistently asked CMS to prioritize its education and outreach efforts and develop more timely resources that educate providers and practice staff to help them to understand feedback well enough to translate the information into meaningful improvements in their practices.

Alternative Payment Models

Payment Incentive for APM Participation

CMS: *How should CMS define 'services furnished under this part through an eligible APM (EAPM) entity'? What policies should the Secretary consider for calculating incentive payments for APM participation when the prior period payments were made to an EAPM entity rather than directly to a qualifying participant (QP), for example, if payments were made to a physician group practice or an ACO? What are the effects of those policies on different types of EPs (that is, those in physician-focused APMs versus hospital-focused APMs, etc.)?*

MACRA stipulates that, for 2019 through 2020, providers may be considered either a partial QP or a QP for purposes of determining participation in an eligible APM. This distinction is determined through a threshold that is based on a certain percentage of Medicare Part B payments for covered professional services that are furnished through an eligible APM in the most recent reporting period. In 2021, this threshold may consider a combination of all-payer and Medicare revenues for purposes of making this determination, which will establish how many participants will receive the lump sum 5% incentive payment.

In order to define "services furnished under this part through an EAPM entity," MGMA recommends that CMS consider that APMs will vary immensely in structure. Consequently, this definition will require as much flexibility as possible to account for different organizational governance structures, the level of physician leadership in the entity, and the manner in which it is paid (fee-for-service, population-based payments, or capitation). MGMA believes that CMS has an opportunity during the application process to require the APM to establish how revenues will be distributed to providers in the APM. For instance, an APM that only looks at revenues for physician and professional services will use a different method for determining revenue thresholds than another APM that counts both revenues for hospital and post-acute care services. For these reasons, defining these thresholds should be malleable and determinable by the APM in its application process, and discussed in partnership with CMS so innovation is not stifled.

Nominal Financial Risk

CMS: *What is the appropriate type or types of "financial risk" under section 1833(z)(3)(DD)(ii)(1) of the Act to be considered an EAPM entity? What is the appropriate level of financial risk "in excess of a nominal amount" under Section 1833(z)(3)(D)(ii)(1) of the Act to be considered an EAPM entity?*

The definition of "more than nominal financial risk" should not be based on the relative gain or loss to the Medicare Trust Fund, but on how much the physician practice or the APM entity itself gains or loses. "More than nominal financial risk" should be defined to allow for physicians to take accountability for services they can truly influence and not for aggregate Medicare

spending. The financial risks associated with creating and operating an APM can be staggering, considering that in many cases, organizations do not see a return on their investments for several years, if at all. Start-up costs for ACOs, specified by MACRA as a current example of an APM, often top $4 million, according to a 2013 study by the National Association of Accountable Care Organizations. APMs will require operating capital to finance data analysis for care coordination strategy development, investments in health information technology, ongoing costs for care managers and personnel.

Quality Measures

CMS: *What criteria could be considered when determining "comparability to MIPS" of quality measures used to identify an EAPM?*

CMS should make every effort to harmonize measures across all programs, including MIPS and APMs. At the same time, CMS should not tie the hands of an APM by defining it through the lens of MIPS, which is intended to be a separate program for this very reason. MGMA recommends that the APM utilize a set of quality measures that align with the overall goal of the organization. We underscore the importance for clinical equivalence in establishing this definition of 'comparability.' There should be a minimum clinical standard across all CMS programs, including MIPS and APMs. However, providers participating in an APM should have a significant opportunity to decide and potentially develop new measures that grant them the flexibility to most accurately represent the goal and design of the APM while still demonstrating quality performance.

Use of Certified EHR Technology

CMS: *What components of certified EHR technology as defined in section 1848(o)(4) of the Act should APM participants be required to use? Should APM participants be required to use the same certified EHR technology currently required for the Medicare and Medicaid EHR Incentive Programs or should CMS other consider requirements around certified health IT capabilities?*

While the certification process established by the Office of the National Coordinator for Health Information Technology (ONC) and performed by Authorized Certification Bodies (ACBs) has been successful to a point in establishing that certified software products meet a minimum set of requirements to count towards EHR participation in the Meaningful Use Program, it has failed in a number of critical areas. First, and most importantly, there is no requirement that the software actually improve the clinician's ability to provide high-quality patient care. Inadequate EHR design is a roadblock to direct interaction with patients as clinicians are now forced to expend additional time documenting information required by Meaningful Use.

Clinicians report that features such as pop-up clinical decision support reminders, awkward menus and shoddy user interfaces are hindering performance. We urge the government to drive development of EHRs that augment and enhance the clinician-patient encounter. EHRs should also be designed to better facilitate electronic patient engagement. Often, the patient engagement component of the EHR, a critical component of Meaningful Use, does not meet the needs of either the clinician or the patient. Expensive, cumbersome to sign up for and navigate, and security-challenged, portals have a ways to go before they are seamlessly integrated into practice

workflow. Incorporating increased interoperability between EHR systems and patients' mobile technologies and telehealth technologies, through a modified certification process, would be a pathway to improving patient engagement.

CMS: *How should CMS define "use" of certified EHR technology as defined in section 1848(o)(4) of the Act by participants in an APM? For example, should the APM require participants to report quality measures to all payers using certified EHR technology or only payers who require EHR reported measures? Should all professionals in the APM in which an eligible alternative payment entity participates be required to use certified EHR technology or a particular subset?*

We agree that APMs should require a baseline set of technology functionality bearing in mind that technology should support the APM, not define it. Current certification requirements significantly limit the utility of CEHRT to APMs by requiring expensive functionalities that are often irrelevant to the APM. We urge the government to establish a set of more appropriate baseline functionalities which should be developed with input from the physician community and then communicated to potential APM participants. Adoption of these functions could be incorporated as a component of the APM application process. This approach would ensure that practices implements a baseline standard of technological functionalities with the ability to customize additional capabilities that are more in sync with the specific needs of that APM. Importantly, this would not require APMs to purchase prohibitively expensive software that add no additional benefits for the APM and only serve to act as a disincentive to APM participation.

CMS: *What are the core health IT functions that providers need to manage patient populations, coordinate care, engage patients and monitor and report quality? Would certification of additional functions or interoperability requirements in health IT products (for example, referral management or population health management functions) help providers succeed within APMs?*

Few of the current certification requirements facilitate effective management of patient populations, assist in referral management or effectively support coordination of patient care. Replacing a formal and costly certification process with an APM technology attestation model would have a number of benefits. For example, the APM-related certification cost would be eliminated for vendors, resulting in decreased software costs for practices. Most importantly, vendors could concentrate attention on innovating software and improving the usability of their products, including customizing systems to fit an APM's unique set of needs.

Physician-Focused Payment Models

CMS: *How should physician-focused payment models be defined?*

Physician-focused payment models should allow physicians to earn incentive payments intended for qualifying APMs without having to meet the criteria established under MACRA to be considered an eligible APM. It is critical that CMS establish transparent criteria and a clear pathway for models to be proposed to the PTAC and for those models that are ultimately recommended by the PTAC to HHS to be implemented by CMS as qualified APMs. CMS and the PTAC should work collaboratively with medical societies and other organizations to develop criteria, provide feedback on drafts, and provide data up-front to help in modeling impacts.

Physician-focused payment models should support innovative approaches that give physicians the flexibility to deliver a more unique set of services than the restrictive requirements that payment systems currently allow. Administrative requirements should also be kept to a minimum, so that resources are spent helping patients, not covering increased administrative costs.

Conclusion

We appreciate the opportunity to offer our perspectives on implementation of the MIPS and APM programs. Should you have any questions, please contact Anders Gilberg at agilberg@mgma.org or 202-293-3450.

Sincerely,

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President and CEO