Nov. 20, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
Submitted electronically: https://www.surveymonkey.com/r/macra-cost-measures-field-testing

Re: MACRA Episode-Based Cost Measures Field Testing

Dear Administrator Verma:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the Centers for Medicare & Medicaid Services' (CMS') request for feedback regarding eight episode-based cost measures for potential use in the cost performance category of the Merit-based Incentive Payment System (MIPS), released Oct. 16, 2017.

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

We would be remiss if we did not begin this letter by expressing our disappointment with CMS' decision in the CY 2018 Updates to the Quality Payment Program (QPP) final rule to count cost as 10% of a clinician's or group's final MIPS score. As discussed in more detail below and reiterated in our comments since the start of MIPS, we have reservations about the current cost category methodology and the agency's readiness to accurately evaluate resource utilization at the individual clinician or group practice level. MGMA has persistently called on CMS to reweight the cost performance category to zero until the agency has extensively tested the new episode-based measures, reformed and fully tested the patient attribution methodology, and implemented risk- and specialty-adjustment to avoid penalizing physician practices who treat the country's most vulnerable patients. None of these shortfalls have been adequately resolved.

The agency cites its desire to educate physicians about the cost category in 2018 as its rationale for plowing ahead. However, because the cost category is undergoing significant changes – not

1717 Pennsylvania Ave. NW, #600 . Washington, DC 20006 . T 202.293.3450 . F 202.293.2787 . mgma.org

least of which is a move to episode-based cost measures and away from the problematic Value-Based Payment Modifier measures that will be used in 2018 – we believe most of this education will be for naught. In fact, it could have the opposite effect in driving physicians and group practice executives to believe the MIPS program will arbitrarily measure their resource utilization. As a result, we believe CMS will do more harm than good by counting cost prematurely.

Utilize a transparent methodology and integrate provider feedback

MGMA recognizes the episode-based measure development process includes multiple levels of multi-specialty clinician feedback and stakeholder engagement. We urge CMS to fully incorporate the recommendations and concerns that result from the stakeholder engagement process. In addition, MGMA offers the following principles to guide the agency as it develops cost measures:

- Measure specifications should be fully transparent and available for public review.
- Measures should be evidence-based, broadly accepted, clinically relevant, actionable, continually updated and developed by practicing physicians.
- Measures must never stifle or restrain clinical innovation.
- Emphasis should be placed on statistically significant cases to minimize the margin of error. Insufficient sample size should be clearly noted in an unbiased manner.
- Data should be risk-adjusted to consider variables that affect health outcomes, including patient demographics, severity of illness and comorbidities.

Streamline access to cost measure feedback reports

MGMA strongly supports CMS' goals of reducing regulatory burden on physicians so they are able to focus on patients over paperwork. CMS can alleviate needless bureaucracy by eliminating barriers to access Medicare quality and cost feedback reports. As CMS increases reporting requirements and feedback related to MIPS and physician payment, the agency should streamline access to these programs through one physician portal – whether it is the CMS Enterprise Portal or the forthcoming QPP Portal – and a single set of criteria for physician delegation to a surrogate user. One portal should provide access for purposes of reporting MIPS information, reviewing CMS feedback about the MIPS information, previewing any information that may be publicly reported, and any other administrative tasks that may arise in the program, such as filing an appeal. Physicians should not need to create a surrogate user for different aspects of the Medicare Part B quality reporting program, and physician delegation to practice staff should be a simplified, one-time process.

To further reduce burden, CMS should provide all cost information in a single report using a consistent format reflecting the recommendations below. This would include cost information pertaining to the total per capita cost and Medicare Spending per Beneficiary measures, along with applicable episode-based measures. Based on feedback from MGMA members, we suggest the format used to provide episode-based cost measure feedback, although not without faults, is superior to the Quality and Resource Use Reports and therefore preferred.

1717 Pennsylvania Ave. NW, #600 . Washington, DC 20006 . T 202.293.3450 . F 202.293.2787 . mgma.org

Expand access to episode-based cost measure feedback

MGMA urges CMS to make the episode-based cost reports more widely available. We believe CMS should make reports available to clinicians and group practices who had at least one attributable episode of care. Further, CMS should consider providing cost data to any clinician who is involved in furnishing care during an episode, even if he or she is not ultimately attributed the episode, to ensure they are able to understand how their resource utilization affects the overall episode. Although the agency may not be able to score cost performance in these instances, CMS can and should provide patient-specific data relevant to the episode of care. MGMA has long advocated for greater feedback in the Medicare quality reporting programs and urges CMS not to be frugal in its feedback program given the rising importance of cost in determining physician payment.

Additionally, MGMA has concerns the current attribution methodology may undermine care coordination and the group practice model of care by assigning the episode to a single provider or practice. CMS can combat this effect by making cost feedback readily available to all participants in the patient's care. It is also essential that CMS expand access to feedback reports in coordination with the agency's implementation of the patient relationship categories, which presumably will allow CMS to begin apportioning episodes to multiple clinicians or group practices who provide care during the episode.

In any instance in which a group practice does not receive a feedback report, CMS should include an indicator to this effect in the portal and provide an explanation specifying why a group practice did not receive a report. For instance, the group may not have been involved in any of the assessed episodes of care. Practice administrators and group representatives should not be left to question a missing report but rather should be able to quickly verify that they have not received a report for lack of data, rather than a technical or human error.

Improve the readability and actionability of episode-based cost measure reports

MGMA members who accessed and reviewed the practice-specific and mock reports overwhelmingly found the information difficult to understand and use. One practice administrator who works with a solo practitioner summarized her experience reviewing their practice-specific reports as follows: "the man-hours it takes to decipher and report data in so many various ways, at some point becomes cost prohibitive for a practice." CMS should understand that while those who create the reports are experts in health economics, those who review them and who will ultimately reduce wasteful utilization do not have PhDs in economics. Rather, they are busy physicians and practice executives.

To better serve the target audience of these reports, CMS should ensure, at a minimum, that the reports can be reviewed independent of other sources. In other words, the reports should include all relevant information, including measure specifications and definitions, in an easy-to-access format. Currently, practice administrators must download a separate file to reference the measure specifications and, in certain cases, even contact the QualityNet Help Desk for assistance understanding certain definitions and terms of art. Further, some of the terminology has a meaning different from the colloquial definition and should be carefully referenced in the reports

1717 Pennsylvania Ave. NW, #600 . Washington, DC 20006 . T 202.293.3450 . F 202.293.2787 . mgma.org

and in related webinars and fact sheets. For instance, when discussing patient attribution, the reports and accompanying documents should be careful to specify whether "plurality" refers to volume of services or allowed charges.

It would not be sufficient to merely improve the functionality of the report. CMS must go beyond improving the readability of these reports to improve the actionability of the feedback. The practice administrator of a large, multi-specialty practice who reviewed the mock report stated, "from the perspective of a private practitioner there is little information that offers an opportunity to control the cost or to consider alternative options to effect cost savings." MGMA encourages CMS to provide detailed, patient-level information pertaining to the clinical themes, subgroups, and risk adjustment information included in the report. Regarding the clinical themes, the agency should explain how these topics are cost-drivers and what lower-cost practice professionals are doing to reduce their costs in these areas. For instance, are they referring patients to lower-cost specialists or facilities? If so, CMS should provide data about the cost of the referrals and facilities included in the episodes.

Another major shortcoming of the feedback is its divorce from the quality efforts of physician groups. CMS should consider how the costs of clinical services, particularly the choice among care alternatives, are linked to the quality of care and patient outcomes. At the outset of development of these episode-based measures, CMS should make every effort to align cost and quality metrics. One suggestion would be to utilize data reported via electronic health record or qualified registry. Many group practices have invested significantly in registries and EHR dashboards that provide near-real-time information about the quality of care. One practice administrator of a single-specialty gastroenterology group practice found little usefulness in the episode-based cost measure report relative to the information provided by their registry. We encourage CMS to work closely with the qualified registry and EHR vendors to improve data collection and communication to provide feedback about patient outcomes resulting from different care pathways.

Finally, even easy-to-understand, patient-level, quality-aligned feedback will not be actionable if it is provided months after the episode of care concludes. Delays in feedback prevent group practices and physicians from adjusting their work flows and spending patterns until well into the next performance period. In the case of cost measures, more frequent feedback is particularly critical as CMS conducts all calculations using claims data and, as a result, a group practice may not even be aware of attributed episodes of care while they are underway. In fact, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) recognized the critical importance of current feedback and instructs CMS to provide feedback on a quarterly basis. MGMA urges CMS to prioritize infrastructure improvements necessary to provide timely feedback about cost and patient attribution.

Support the group practice team-based model of care

MGMA urges CMS to ensure the episode-based cost measures reflect the group practice model of care where multiple practitioners utilize a team-based approach to treating patients. In fact, the fundamental advantage the group practice model offers is the coordination of a wide range of physician and related ancillary services in a manner that is seamless to patients. Physician

1717 Pennsylvania Ave. NW, #600 . Washington, DC 20006 . T 202.293.3450 . F 202.293.2787 . mgma.org

practices have a goal of collectively improving care through coordination, efficient use of resources, investment in effective health information technology and employment of practice improvement initiatives. This holds true whether the group is single- or multi-specialty, physician-owned or non-profit practice, or part of an integrated health system. By establishing a group practice reporting and assessment option in MIPS, the agency recognized the value of analyzing quality and cost under the umbrella of a group practice and should do so going forward in developing the episode-based cost measures.

Further, as physician practices transform in preparation for alternative payment models (APMs) and increased financial accountability, these organizations are adopting physician-led multidisciplinary teams that focus on coordination across the care continuum to guide patients through an acute episode of care or to provide care to patients with ongoing, complex care needs. For example, CMS' Comprehensive Primary Care Plus demonstration requires group practices to "develop a personalized plan of care for high-risk patients and use team-based approaches like the integration of behavioral health services into practices to meet patient needs efficiently." MGMA strongly urges CMS to explore ways to account for a physician-led, multidisciplinary team approach to patient care. CMS should work closely with the developers of care episodes and physician specialty organizations to determine best practices for distributing the costs of care within episodes to ensure accurate attribution.

Provide sufficient opportunity for review and appeal of final cost measures

Finally, MGMA urges CMS to establish a robust and efficient review and appeals process that would allow providers and practice administrators to submit clinical or other relevant data to supplement and correct inaccurate data and cost attributions. To facilitate this process, CMS should provide detailed information about each attributed episode of care.

We appreciate your consideration of these comments. If you have any additional questions, please contact Jennifer McLaughlin at 202.293.3450 or jmclaughlin@mgma.org.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs

1717 Pennsylvania Ave. NW, #600 . Washington, DC 20006 . T 202.293.3450 . F 202.293.2787 . mgma.org