



June 24, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule

Dear Acting Administrator Slavitt:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the proposed rule entitled, “Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule (PFS), and Criteria for Physician-Focused Payment Models; Proposed Rule” released on May 9, 2016 with file code CMS-5517-P. We look forward to continuing to work with the Centers for Medicare & Medicaid Services (CMS) on implementing MIPS and APMs successfully.

MGMA and its 50 state affiliates comprise more than 33,000 administrators and executives in 18,000 healthcare organizations in which 385,000 physicians practice. MGMA represents physician groups of all sizes, types, structures and specialties, and has members in every major healthcare system in the nation. As the leading association for practice administrators and executives for nearly 90 years, MGMA produces the most credible medical practice economic data in the industry and provides the education, advocacy, data and resources that healthcare organizations need to deliver the highest-quality patient care.

Introduction

With the support of MGMA and the physician community, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the flawed sustainable growth rate formula and set Medicare physician payment on a trajectory away from fee-for-service and toward value-based reimbursement of high-quality healthcare. MACRA established transitional payments to support physician practices that are transforming the way they deliver care through participation in APMs with Medicare and commercial payers. MACRA also recognized the administratively onerous and duplicative requirements across the current hodgepodge of federal quality reporting programs are distractions from practice improvement and providing high quality care for

patients. According to a Health Affairs study of MGMA member practices, each year physician practices in four common specialties spend, on average, 785 hours per physician and more than \$15.4 billion on quality measure reporting programs. As the study cites, the majority of time spent on quality reporting consists of “entering information into the medical record only for the purpose of reporting for quality measures from external entities,” and nearly three-quarters of practices stated their group was being evaluated on quality measures that were not clinically relevant. Congress recognized the pitfalls of these programs in driving clinicians’ time away from patients and toward paperwork, and, as a result, replaced them with a single, streamlined quality program, known as MIPS.

MGMA believes the MIPS and APMs proposed rule strays significantly from the terms and themes of MACRA. Further, as proposed, the framework of these programs would not achieve CMS’ overarching goal of promoting high-value healthcare through patient-centric, flexible and streamlined payment incentives. During a recent MGMA webinar about the proposed MIPS program, 65% of the nearly 500 participants responded that this proposed rule would not only fail in achieving its goal of improving clinicians’ ability to deliver high-value care, it would actually detract from it. MGMA and our members recognize proposed MIPS criteria are so onerous that, when coupled with an almost non-existent Advanced APM pathway, they would consume clinicians’ time and resources in collecting and reporting what are essentially government-mandated data points rather than spending time with patients.

When reviewing this proposal in conjunction with MGMA’s feedback and the input from other stakeholders, it is critical CMS bear in mind not only the terms of MACRA, but also the principal themes of the statutory language that established these programs. On the House floor, U.S. Representative Michael Burgess, one of the authors of MACRA, described the law’s goals to “reduce and streamline the administrative burden; increase predictability and provider’s interactions with CMS; build transparency into systems; encourage innovation of delivery of services; and keep providers in the driver’s seat.”

With the provisions and intent of MACRA in mind, MGMA offers the following recommendations to improve the proposed regulatory framework of MIPS and APMs:

- **Begin the first MIPS performance period no sooner than Jan. 1, 2018.** Following publication of the final rule and ahead of the start date, the agency must devote significant resources to educate practices about this complex program. Most importantly, beginning Jan. 1, 2018 would bring the measurement period closer to the payment year.
- **Shorten the quality and advancing care information (ACI) performance periods to any 90 consecutive days using sampling and attestation methodologies that ensure statistical validity. Accommodate claims-based reporting with a longer submission period, such as six months.** Ninety days would align quality and ACI with the proposed 90-day CPIA performance period.
- **Finalize the MIPS group practice assessment option,** which recognizes the fundamental advantage the group practice model offers by coordinating a wide range of

physician and related ancillary services in a manner that is seamless to patients. This holds true whether the group is a single- or multi-specialty, physician-owned or non-profit practice, or part of an integrated health system.

- **Reduce the reporting requirements across MIPS.** As proposed, physician group practices' finite resources would be spread across at least 20 measures and objectives, including a minimum of eight measures in the quality category, two measures in resource use, nine measures in ACI, and at least one measure in the clinical practice improvement activity (CPIA) category. CMS should structure MIPS to allow practices to prioritize effective and impactful improvements to patient care, rather than comply with sprawling reporting mandates.
- **Award credit across MIPS performance categories.** Whenever possible, CMS should award credit in multiple categories to streamline the program and reduce redundancies. Clinicians should receive full ACI credit when they report quality measures via end-to-end electronic reporting or leverage certified EHRs to engage in CPIAs. Additionally, a number of the CPIAs have a quality or resource use focus and should be counted towards both.
- **Simplify the ACI component of MIPS** by removing the proposed all-or-nothing base score approach and deeming eligible clinician (EC) attestation to using 2014 or 2015 CEHRT as fully meeting the ACI component for the 2019 payment year and 75% of all additional payment years. Further, the Performance Score reporting options should be significantly expanded to permit clinicians to select the measures that better reflect their care delivery approach.
- **Reweight the MIPS resource use performance category to zero** until CMS has extensively tested the new episode-based measures, reformed the patient attribution methodology, and implemented key aspects of this category, including patient relationship codes and risk adjustment recommendations from a forthcoming congressionally-mandated report.
- **Provide clear and actionable feedback about MIPS performance every calendar quarter**, as recommended by the statute. Without transparent criteria and timely feedback, MIPS is essentially a reporting exercise that enters data into a "black box" only understood by CMS, rather than a useful barometer practices can leverage to drive quality improvement.
- **Overhaul the eligible APM criteria and expand the list of qualifying APMs** to include legitimate CMS Innovation Center models such as Medicare Shared Savings Program (MSSP) Track 1 ACOs and the Bundled Payment for Care Improvement (BPCI) models.
- **Seek opportunities to adopt private sector payment models and patient-centered medical home (PCMH) models as eligible APMs.**

Merit-Based Incentive Payment System (MIPS)

Performance period

CMS proposal (p. 28179): CMS proposes to establish the MIPS performance period as the calendar year two years prior to the MIPS payment adjustment year. For example, Jan. 1 through Dec. 31, 2017 would be the performance period for 2019 MIPS payment increases and decreases. If a clinician has less than 12 months of performance data to report, such as when a clinician switches practices during the performance period or stops practicing (e.g., a clinician who has an illness or is on maternity leave), the clinician would be required to report on all available performance data.

MGMA comment: To ensure physician practices and their trading partners have sufficient time to prepare, make the necessary investments and upgrades, and implement the necessary work flow changes to be successful under MIPS, CMS should begin the first performance period no earlier than Jan. 1, 2018. More importantly, moving the performance period to Jan. 1, 2018 would shorten the gap between MIPS performance and payment periods. It will also provide more time for development of eligible APMs. Specifically, a start date of Jan. 1, 2018 gives the Physician-Focused Payment Model Technical Advisory Committee (PTAC) an opportunity to begin reviewing and recommending physician-focused payment models for expansion as eligible APMs.

Although many of the proposed deadlines for submitting MIPS data to CMS would not occur until the first quarter of 2018, this alone does not buy practices adequate time to transition. To operationalize a quality reporting program, physician practices must take many steps prior to the start of the performance period to ensure that the proper systems are in place and the necessary data is being accurately collected throughout the performance year so that it can be properly submitted during the subsequent attestation period. For example, clinicians and practices must select the requisite number of clinically-relevant measures, train their staff, and input the measure information as discreet data into the EHR. Otherwise, a third-party data submission vendor or registry cannot extract the necessary data, nor submit it to CMS. Starting at the outset of the performance period is even more critical for clinicians who report by including quality codes on their Part B claims, because this information must be included when the claim is processed for payment. If the final rule were released tomorrow and vendors and practices had six months to update their products to conform to the new standards, perform the necessary staff training, and get the proper work flows in place, a Jan. 1 start date would still be a herculean task. Add the fact that the CMS Administrator does not expect the MIPS and APMs final rule to be published until the fall, which would leave just two to three months for practices to understand and implement a brand-new program and set of requirements, and that task goes from difficult to nearly impossible.

Moreover, if CMS truly intends to influence clinicians and practices to improve care by evaluating quality, cost, EHR, and practice improvement metrics, the desired evidence-based actions must be taken at the point of care, starting on the first day of the performance period. As a result, starting performance on Jan. 1, 2017, as proposed, would, at best, reduce MIPS participation from a thoughtful and concerted effort to improve the value of patient care into a

sprint toward compliance out of sheer survival, or quite possibly evolve into a winner-take-all scenario in which the practices that have already made investments in infrastructure and technology would excel, while less-resourced practices scramble to catch up or decide not to participate. MIPS offers the Administration a unique opportunity to hit the reset button and reestablish industry confidence in federal quality reporting programs. The Administration will make great strides toward winning back the hearts and minds of physicians by providing practices with sufficient time to digest the final MIPS requirements and operationalize them successfully.

In addition to allowing a reasonable transition period before the start of the first MIPS performance period, MGMA strongly urges CMS to shorten the performance period to the first nine months of the calendar year, followed by three months of data analysis by CMS to calculate MIPS scores and payment adjustments. MGMA also recommends that CMS shorten the reporting period for each of the MIPS categories. Specifically, CMS should reduce the ACI reporting period to 90 days and use a statistically-valid snapshot of quality data. The quality data collection period may vary based on reporting mechanism, but MGMA strongly urges CMS to reduce the period to the minimum statistically-valid sample. For reporting on all-payer data via QCDR, registry, or EHR, any 90-consecutive days should provide a reliable data set. Claims-based reporting may require a longer data collection window, such as six months. As discussed later, MGMA urges CMS to eliminate the total cost of care measures from resource use and delay measuring group practices and clinicians on this category until the episode groups have been tested and the other necessary elements of this category have been implemented. When appropriate, CMS should consider a nine-month data collection period for the resource use episode groups.

There is precedent for CMS to utilize a 90-day reporting period; in both 2014 and 2015 the EHR Incentive Program required a 90-day reporting period. Further, current reporting thresholds can often be met within this condensed time period. For instance, the PQRS measures group reporting option requires a 20 patient sample, which can in many cases can be met in less than 90 days. If practices are able to meet the threshold requirements and provide statistically valid data within a shorter timeframe such as 90 days, there should be no reason to have them expend more practice resources and staff time to report data for reporting's sake.

Moving to a shorter reporting period would also allow for a number of program improvements. First and foremost, it would reduce the administrative burden in MIPS, align the reporting period across MIPS categories, shrink the problematic two-year lag between performance and payment, and increase the relevance and timeliness of feedback, which could be provided on a quarterly basis as recommended by Congress in MACRA. Establishing a 90-day performance period would also give CMS an opportunity to set benchmarks based on more current data, rather than data that is pulled from four years prior to the payment year, as proposed. Additionally, shortening the performance period would give practices the much-needed time to make the necessary preparations to successfully transition from the current programs to MIPS. We acknowledge that certain reporting options, such as claims-based reporting, may require a slightly lengthier reporting period to ensure statistical validity. However, we strongly encourage CMS to look for opportunities to shorten the minimum statistically-valid reporting period across all data submission methods.

Finally, in conversations with CMS officials, we have learned that the agency believes that the physician community would prefer a full calendar year reporting period. However, when we polled MGMA members about their preferred measurement period for the quality and ACI categories, the overwhelming majority (396 of 427 respondents or 92%) stated that they would prefer any 90 consecutive days. If the agency is truly interested in providing physician groups practices with their preferred reporting period, we urge CMS to move forward with a 90-day reporting period.

Group reporting and performance assessment

CMS proposal (p. 28178): CMS proposes to establish a group performance assessment option for MIPS. To have performance assessed as a group, at least two individual ECs must reassign their billing rights to the group's tax identification number (TIN) and the group would need to elect to have its performance assessed as a group across all four MIPS performance categories. ECs within the group would aggregate their performance data across the TIN.

MGMA comment: MGMA strongly supports a group practice level evaluation in MIPS. Physician practices have a goal of collectively improving care through coordination, efficient use of resources, investment in health information technology (HIT), and practice improvement initiatives. Additionally, measurement at the group practice level will result in more statistically valid performance scores because the scores are aggregated to represent a larger group of clinicians.

Performance identifiers

CMS proposal (p. 28176): CMS is not proposing to create a new MIPS EC identifier. Instead, CMS would use existing Medicare identifiers when evaluating individual ECs, group practices, and APM Entities under MIPS. Specifically, ECs that choose to be measured on an individual basis would be evaluated at the TIN/national provider identifier (NPI) level. Group practices that register to be measured collectively through the group's performance would be evaluated at the TIN level. CMS would continue to define groups as a single TIN with two or more MIPS ECs who have reassigned their billing rights to the TIN. Finally, CMS proposes to evaluate APM Entities exclusively at the APM Entity level. For payment purposes, each participant would be identified by a combination of four identifiers: (1) APM identifier, (2) APM Entity identifier, (3) TIN, and (4) NPI.

MGMA comment: MGMA supports CMS' proposal to use existing Medicare identifiers for purposes of MIPS performance and payment, rather than create a unique 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.

As previously stated, MGMA urges CMS to finalize its proposal to evaluate MIPS performance at the group practice level, which recognizes the advantages of the group practice model in coordinating care, developing a robust HIT infrastructure, demonstrating clinical practice improvement, and identifying and reducing potentially wasteful resource use – all of which are

necessary ingredients for success in MIPS. We agree that CMS should utilize a group's existing TIN as its MIPS identifier.

Payment adjustments and identifiers

CMS proposal (p. 28271): CMS proposes to apply MIPS payment adjustments at the individual clinician level based on the TIN/NPI identifier, regardless of whether the clinician elects to report as an individual or as a group. In cases where there is no composite performance score (CPS) associated with a TIN/NPI from the performance period, the agency would use the NPI's performance for the TIN(s) the NPI was billing under during the performance period. In scenarios where the MIPS EC billed under more than one TIN during the performance period, and the MIPS EC starts working in a new practice or otherwise establishes a new TIN that did not exist during the performance period, CMS proposes to use a weighted average CPS based on total allowed charges from the multiple TINs associated with the NPI from the performance period. Alternatively, CMS proposes to use the highest score.

MGMA comment: CMS should apply MIPS payment adjustments at the group practice level using the group's TIN. Value-based improvements are largely designed and implemented at the group practice level. MGMA is concerned that applying a MIPS payment increase or decrease at the individual level would undercut a practice's ability to incentivize quality improvement behaviors among all of its staff – including but not limited to clinicians - and collectively manage the impact of MIPS. MGMA urges CMS to continue supporting and encouraging the group practice model by applying MIPS payment adjustments at the TIN level and allowing practices to determine their own effective compensation plans, as the agency currently does in the current Medicare payment system.

Applying the MIPS payment adjustments at the individual provider level would also create a chaotic scenario in which every physician and practitioner in a group is subject to different Medicare conversion factors, which would add further complication anytime a provider switches practices. Basing performance and payment adjustments on the TIN, rather than the individual NPI, would reduce administrative burden on practices, equalize payment adjustments across all clinicians in the TIN, and create incentives for clinicians to move to higher-performing practices, creating an overall more competitive quality environment in healthcare.

Applying the MIPS payment adjustment at the TIN level would also help achieve CMS' aim of closing potential loopholes through which clinicians may avoid a MIPS payment reduction by switching identifiers. Dissolving an existing TIN and creating a new one typically entails renegotiating payer contracts and is an altogether expensive and time-consuming undertaking that serves as a deterrent to switching identifiers solely for the purpose of dodging a MIPS payment adjustment. Tying MIPS payments to a group practice's existing TIN would not only serve to streamline the program and reduce billing complexities, but also would have the added bonus of reducing the likelihood that clinicians could elude MIPS payment reductions by switching identifiers.

Exclusions

CMS proposal (p. 28177): The statute requires CMS exclude from MIPS newly-enrolled ECs, ECs who are qualifying APM participants (QPs) and partially-qualifying APM participants (Partial QPs), and ECs with a low volume of Medicare patients. CMS proposes to define a newly-enrolled EC as a professional who first enrolled in Medicare within the Provider Enrollment, Chain, and Ownership System (PECOS) during the performance period and who has not previously submitted claims as a Medicare-enrolled EC as an individual, entity, part of a physician group, or under a different billing number or tax identifier. Under these rules, an EC who enrolls in Medicare in 2017 for instance would not be required to participate in MIPS until 2018. CMS proposes to define clinicians and groups who fall below the low-volume threshold as having Medicare billing charges of \$10,000 or less and providing care to 100 or fewer Medicare Part B beneficiaries.

MGMA comment: In MACRA, Congress recognized small practices often lack the infrastructure and resources to comply with complex quality reporting programs, particularly when Medicare patients make up a small portion of their patient mix, and established the low-volume threshold to mitigate adverse effects on small and rural practices. However, as proposed, the low volume threshold definition would dramatically reduce the exemption's impact. According to an analysis by the American Medical Association (AMA) of the 2014 "Medicare Provider Utilization and Payment Data: Physician and Other Supplier," just 10% of physicians and 16% of all MIPS ECs would be exempt under the \$10,000 and 100 beneficiary proposal and these clinicians account for less than 1% of total Medicare allowed charges for PFS services. If the threshold remains this low, Medicare risks deterring physicians, especially in certain specialties that see relatively few Medicare patients such as gynecology and psychiatry, from treating Medicare beneficiaries altogether. By raising the threshold to \$30,000 in Medicare allowed charges and changing the "and" to "or," CMS would exclude approximately one quarter of physicians practicing in small and rural areas, thereby protecting access to important healthcare services for Medicare beneficiaries in these areas, while still subjecting more than 95% of allowed spending to MIPS standards. For these reasons, MGMA strongly recommends CMS amend the low-volume threshold to 100 beneficiaries or \$30,000 in billable charges.

MGMA also believes CMS' definition of low-volume threshold should be appropriately scaled for group practices according to the number of ECs who reassign their Medicare billing rights to the group. In fact, it seems likely the proposed definition includes a drafting error, such that the same standard would be applied to both solo practitioners and group practices. If uncorrected, this definition would significantly disadvantage groups of clinicians that, in the aggregate, rarely care for Medicare patients, but include one or two members that actively participate in the program. CMS should raise the encounter threshold for group practices according to the number of ECs that reassign their billing rights to the group's TIN.

Additionally, CMS should 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. Failing to inform providers of their MIPS eligibility and APM qualification at the outset of the performance period would result unfavorable assessments and carry heavy penalties that

could have been avoided had the agency clearly and accurately communicated this information earlier.

Non-patient facing eligible clinicians (ECs) and group practices

CMS proposal (p. 28381): CMS proposes to consider clinicians and groups that bill 25 or fewer patient-facing encounters, including telehealth services, during a performance period as non-patient facing. Non-patient facing ECs and groups are not required to report on any cross-cutting measures within the quality category of MIPS. CMS also anticipates that many non-patient facing clinicians and groups would be excluded from the resource use performance category for lack of attributed measures.

MGMA comment: MGMA believes CMS' definition should be appropriately scaled for group practices according to the number of ECs who reassign their Medicare billing rights to the group. In fact, it seems likely that the proposed definition includes a drafting error, such that the same standard would be applied to both solo practitioners and group practices. If uncorrected, this definition would significantly disadvantage groups of specialists that, in the aggregate, rarely care for patients in a face-to-face manner but include one or two members that bill patient-facing encounters. CMS should raise the encounter threshold for group practices according to the number of ECs that reassign their billing rights to the group's TIN. For example, if five ECs belong to a group practice, the threshold should be set at 125 patient-facing encounters.

Additionally, we urge CMS to restrict the definition of "telehealth services" to a direct interaction with patients and not a telehealth consultation with another clinician. At a minimum, CMS should publish a comprehensive listing of each telehealth service determined to be "patient-facing" at the beginning of the performance year so it is clear to clinicians whether they would be excluded from MIPS.

Virtual groups

CMS proposal (p. 28179): MACRA requires CMS establish a process that allows an individual EC or group consisting of not more than 10 ECs to elect to form a virtual group with other ECs and groups. Due to the insufficient timeframe to develop the necessary technological infrastructure including a registration platform, CMS believes it would not be feasible to implement virtual groups for the 2017 MIPS performance year. The agency intends to implement virtual groups for the 2020 payment year and to address the details of this option in future rulemaking.

MGMA comment: Because there are many details that distinguish this largely untested and undefined mechanism from a group practice, MGMA urges CMS to consider renaming this option a "virtual network." Unlike a group practice, which offers and coordinates a wide range of physician and related ancillary services under one roof in a manner that is seamless to patients, a virtual network would align multiple group practices and clinicians operating across the medical community to report in MIPS. Rather than creating confusion about the bounds of a virtual group, CMS should use its authority, as it did in changing the names of Meaningful Use and MACRA, to clarify this mechanism and rebrand it as the virtual network option.

Additionally, MGMA urges CMS to consider the flexibility afforded by MACRA under Section 1848(q)(5)(I)(ii), in which a virtual network *may* be based on appropriate classifications of providers, such as by specialty designations or geographic areas. As CMS works to implement this 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 network, is not the same as defining this reporting option. In addition, the lack of framework raises the risk of potential future compliance and anti-trust issues. We encourage the agency to take a more active role in this dialogue so stakeholders can work with CMS to mold the virtual network option into a viable reporting method.

Performance options for facility-based clinicians and groups

CMS proposal (p. 28192): CMS seeks comments on the feasibility and appropriate timing for incorporating measures from other systems into MIPS for clinicians who work in facilities, such as inpatient hospitals. CMS also seeks comments on whether it should attribute a facility's quality and resource use performance to a clinician or group, possible criteria for this attribution, and whether it should be automatic or elected by the facility through a formal registration process.

MGMA comment: CMS should make every effort to streamline and coordinate the quality reporting programs across sites of service and to give credit for existing quality improvement performance where performance is largely directed by hospital-based physicians. Because hospitals and other facilities are already collecting this data, CMS should seek opportunities to reduce duplicative data collection, which would result in administrative simplifications across the Medicare program and encourage care coordination. CMS would need to ensure that the performance measurements are clinically relevant and should coordinate with the applicable medical specialties to incorporate appropriate attribution, risk adjustment and other factors that may impact performance.

Data submission and integrity

CMS proposal (p. 28181): CMS would require data submission from clinicians and groups in the quality, ACI, and CPIA categories. As proposed, there are no data submission requirements for the resource use category, certain CPIA efforts, and the population health outcomes measures calculated under the quality performance component. These components of MIPS would instead be assessed by CMS using administrative claims. CMS proposes to retain all of the data submission mechanisms from PQRS, including claims, registry, EHR, qualified clinical data registry (QCDR), web interface (groups with 25 or more ECs only), and survey vendors (groups only). CMS also proposes that both individual ECs and groups may attest to the ACI and CPIA categories.

MGMA comment: MGMA urges CMS to finalize its proposal to maintain all of the current PQRS reporting mechanisms to provide flexibility for clinicians and groups with varying levels of resources and to provide continuity as practices transition to MIPS. It is critical that the initial transition to MIPS is as seamless and non-disruptive to clinical practice as possible, and we

support CMS' proposal to provide physicians with the flexibility to continue to report via their preferred mechanism under PQRS.

However, it is critical the agency address the ongoing problems that have been identified involving third-party data submission mechanisms in current quality reporting programs. Specifically, the agency must resolve how clinicians are to be fairly evaluated when their vendor fails to transmit quality data completely and accurately, through no fault of the clinician. On page 28280 of the proposed rule, CMS identifies "a strong consensus that MIPS ECs should not be penalized for signing up with an entity that purported to offer reliable services but then was unable to accurately submit data to us." However, the agency's proposed data integrity plan, which details a process for disqualification and probation of vendors that fail to accurately submit data, is silent on how impacted clinicians and groups would be evaluated under MIPS.

As we saw during the informal review process for the 2016 PQRS performance period, many physicians and group practices were unsuccessful in the program due to vendor transmission issues. For whatever reason, transmission of data from some EHRs and registries inadvertently did not occur or failed, in several cases multiple times, even after corrective action was taken. In instances where practices were able to identify the penalty was a result of a vendor error and filed an informal review, CMS denied the request. The idea that practices can face a penalty for an error that is out of the practice's hands is completely unfair and raises doubt about the integrity of the program.

MGMA strongly urges CMS to establish a two-fold approach to allow impacted groups and physicians an opportunity to participate in MIPS. First, any clinician or group practice who in good faith works with a qualified third-party vendor to submit performance data but whose data is unsuccessfully transmitted by the vendor should be given the opportunity to resubmit and correct data within a reasonable timeframe in the case of any submission problems. This process should explicitly consider and credit evidence provided by the practice, vendor, or registry that a submission was attempted or intended, such as the applicable Quality Reporting Document Architecture (QRDA) file. Second, if resubmission is not feasible, CMS should hold impacted physicians and practices harmless from any penalty under MIPS. Practices should not be unfairly penalized due to inactions or errors of external parties, including vendors, as well as the agency itself.

Furthermore, the agency must also take a proactive, as opposed to reactive, role in communicating submission problems to both vendors and practices during an applicable performance period. Without this vital information, practices may be left in the dark until it is too late to utilize another reporting option. Additionally, CMS should encourage vendors to be forthright if they are unable to meet data submission standards so groups and providers can find an alternative means to report MIPS data.

MIPS quality performance category

Measure reporting criteria

CMS proposal (p. 28184): CMS proposes all patient-facing clinicians and groups must either report on six individual quality measures including at least one outcome measure and one cross-cutting measure, or report one complete specialty or subspecialty measure set. If there are no applicable outcome measures to report, then the clinician or group would need to substitute a high-priority measure, such as an appropriate use, patient safety, efficiency, patient experience, or care coordination measure. The agency also intends to increase the requirements for reporting outcome measures over the next several years through future rulemaking.

MGMA comment: While MGMA appreciates CMS has proposed to reduce the reporting requirement from nine measures under PQRS to six measures in MIPS and to eliminate the requirement to report measures from three different national quality strategy domains, we strongly advise the agency to further reduce the reporting burden in this category by decreasing the reporting requirement to three measures and allowing clinicians and group practices to report additional quality measures at their discretion. Reducing the reporting requirements at the outset of MIPS will help to rebuild physician buy-in for federal quality reporting programs, which is a stated priority of CMS, and the agency may gradually increase the reporting requirements as appropriate through future rulemaking cycles.

MGMA also urges CMS to retain the PQRS measures group reporting option, which currently allows specialties with few clinically relevant measures to report a set of condition- or specialty-specific measures on a sample of 20 Medicare beneficiaries. Many small and specialty groups continue to struggle with identifying clinically relevant measures to report and are unfairly disadvantaged as a result. These penalties are issued not because the groups do not provide high-quality care, but because the measures simply don't apply or because they cannot afford to redirect limited practice resources away from patient care for reporting purposes.

Additionally, MGMA opposes a minimum threshold for outcomes or cross-cutting 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. To incentivize the reporting on outcome measures or cross-cutting measures, CMS should provide bonus points for reporting these types of measures to reward practices that go above and beyond, rather than penalizing providers who simply cannot find applicable measures to report based on their size or specialty, particularly in this first year of the program when practices are still navigating the new requirements and many measures are still being evaluated by CMS.

We also urge CMS to keep in mind the quality performance category is just one of four components of this complex program. As proposed, physician group practices' finite resources would be spread across a minimum of 20 MIPS measures and objectives, including a minimum of eight measures in the quality category, two in resource use, nine in ACI, and one in the CPIA category. This forces practices to split their focus among measures that may not be as relevant to their patient population and clinical specialty, rather than prioritizing their energy and resources

on a few meaningful measures that, if performed well, could move the dial on improving care and reducing costs. By reducing the required minimum number of measures to three, CMS would drastically reduce the administrative burden on group practices in MIPS, improve participation rates, particularly for small to medium practices, and ultimately drive more effective and meaningful quality improvement.

Data completeness criteria

CMS proposal (p. 28188): CMS proposes to drastically increase the reporting volume requirements under the quality category of MIPS and states ECs and groups that fail to meet the data completeness criteria would fail this entire category. To meet the proposed data completeness requirements, CMS would require clinicians choosing to submit quality data via Part B claims to report on 80% of applicable Medicare Part B beneficiaries, up from 50% in PQRS. CMS also proposes to increase the reporting threshold for ECs and groups that report via registry, EHR, or QCDR from 50% to 90% of all applicable patients, regardless of payer.

MGMA comment: Physician practices continue to struggle reporting quality measures for 50% of Medicare patients under PQRS. Although MGMA was disappointed to learn that CMS did not disclose average reporting threshold rates in the 2014 PQRS Experience Report, we have heard from numerous physician practice executives that it is challenging to meet the 50% requirement due to a myriad of issues, including but not limited to system interruptions, vendor upgrades, and other administrative factors often outside the control of the physician or practice. Establishing a data completeness threshold of 80% or 90% would eliminate any wiggle room a group practice has at the precise time the agency is requiring practices to make technological infrastructure changes, which are likely to interrupt reporting, essentially subjecting practices to a double whammy. With everything else that practices must navigate during this period of major transition, increasing reporting thresholds by 30-40% will only set practices up for failure.

Moreover, expanding the majority of the reporting mechanisms to all-payer data collection would dramatically increase both the cost and burden of compliance, not to mention we have heard from many vendors that they will not be able to meet these more stringent requirements, especially in the first performance period.

For these reasons, we strongly urge CMS to reduce the data completeness threshold to 50% of applicable Medicare Part B beneficiary encounters for submission via claims and 50% of all applicable patient encounters for reporting via registry, EHR, and QCDR. MGMA also restates its position that CMS should shorten the quality reporting performance period from one calendar year to any 90 consecutive days, or another statistically-valid sample where feasible.

Measure applicability validation

CMS proposal (p. 28187): If fewer than six quality measures are applicable, CMS proposes to require clinicians and groups to report on each applicable measure. On page 28187, CMS states, “[i]f a MIPS EC or group had the ability to report on the minimum required measures with sufficient sample size and elects to report on fewer than the minimum required measures, then, as described in the proposed scoring algorithm in section I.I.E.6, the missing measures would be

scored with a zero performance score.” However, the agency reveals very few details about how it would evaluate whether the group did in fact report on all applicable measures.

MGMA comment: CMS must clarify in writing its specific process for determining whether a clinician or group reports on a sufficient number of MIPS quality measures. The agency has generated a significant amount of ill will in the PQRS program by conducting the current measure applicability validation calculations behind closed doors. Physician practices could neither verify the accuracy of the outcome, nor challenge its results in a review. This lack of transparency generated distrust in the program and reasonably raised suspicion regarding the agency’s adherence to its own policies.

To change course in MIPS, the agency must disclose the specifics of the measure applicability process in advance of the first performance period. MGMA urges CMS to not only look at the availability of measures based on a provider’s subspecialty or patient condition, but also on reporting mechanism. Although a subspecialty may have sufficient quality measures when CMS looks across all of the MIPS data submission mechanisms, CMS proposes to require reporting via only one mechanism. A clinician or group would therefore be prevented from utilizing multiple mechanisms, such as claims and EHR, to reach the measure requirement. Therefore, CMS should not penalize a provider for failing to report a measure that may be clinically relevant based on subspecialty or condition but is unavailable for reporting via the mechanism that the provider chose.

CMS must continue to rigorously address measurement gaps and improve the existing set of measures by consulting with physician specialties to determine which providers are able to report certain types of measures, including evidence-based process measures. In cases where there are no applicable measures, CMS should work with physician specialties to determine alternative measure options to ensure that all specialties have applicable measures to report, and particularly in early performance years, are not unfairly penalized due to a lack of available clinically relevant measures.

Finally, the agency should also seek every opportunity to give clinicians and groups an opportunity to earn credit for other quality improvement activities. For example, if the group has few relevant quality measures but is engaged in certain CPIAs, CMS should identify ways to provide credit in the quality performance category. We remind CMS that the intent behind creating MIPS was to hit the reset button and put an end to the broken elements of current quality programs to create a truly consolidated and workable program.

Submission criteria for reporting the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS

CMS proposal (p. 28188): CMS proposes administration and submission of the CAHPS for MIPS survey data would be a voluntary reporting option for all groups with two or more ECs. The survey would count as one cross-cutting or one patient experience measure, and the group would need to report five other measures through another reporting mechanism. Groups reporting the CAHPS for MIPS survey would also earn bonus points.

MGMA comment: MGMA supports the agency’s proposal to make the CAHPS for MIPS survey optional for all group practices, rather than required for groups with 100 or more ECs as it is currently under PQRS. However, MGMA urges CMS to consider the CAHPS for MIPS survey an optional activity under the CPIA category. We do not believe patient experience and patient satisfaction should be considered comparable to clinical quality metrics, as factors included in surveys are often outside a physician’s control. Patient satisfaction is important; however, industry research proves that it does not always translate to better clinical outcomes.

Population health measures

CMS proposal (p. 28192): In addition to the quality measures that a group elects to report, CMS proposes to evaluate each group on three population health measures under the quality category of MIPS. Using administrative claims data, CMS would calculate the potentially avoidable hospital admissions for certain acute and chronic conditions as long as there are more than 20 cases per EC or group. For groups with 11 or more ECs, CMS would also calculate an all-cause hospital readmission measure. CMS proposes to continue using the same two-step attribution methodology employed in the now defunct VBPM.

MGMA comment: MGMA strongly opposes CMS’ continued reliance on failed VBPM population health measures. These measures were developed to evaluate outcomes at the community level with 100,000 patients and have very low statistical reliability at the individual clinician and group practice levels. Additionally, because these measures rely on the flawed VBPM patient attribution methodology, they often hold practices and providers accountable for the outcomes of care they had very little influence over, particularly for specialty and rural practices. CMS must take this opportunity to address the myriad of problems identified in the previous programs, including the lack of clinically relevant measures for the vast majority of practices and specialties, and eliminate them from the quality performance category. Rather, CMS should make them optional in the CPIA category, at least until these underlying problems can be studied and addressed.

Scoring of “topped out” measures

CMS proposal (p. 28253): Based on an analysis of 2014 PQRS data, CMS determined half of the current quality measures are “topped out,” which CMS would define as having performance distributions clustered near the top. CMS proposes to set a ceiling on the total point values for these measures, limiting groups and physicians who report these measures in certain circumstances to a maximum of five out of a possible 10 points.

MGMA comment: MGMA opposes CMS’ proposal to further reduce flexibility in MIPS reporting by limiting the point value for topped out measures. We do not believe the quality reporting programs have reached the tipping point where physicians and group practices are selecting “topped out” measures that are easy to report. Rather, we hear regularly from members that they continue to see gaps in the current measure set and, as a result, struggle to find a more diverse set of applicable quality measures from which to select. As the agency expands the quality measure set and ensures that all specialties are able to report the required number of measures across all reporting mechanisms, the agency may begin phasing out “topped out” measures. In the

meantime, however, physicians and groups should not be penalized by reporting measures on the final list of available quality measures that the agency itself developed and approved.

End-to-end electronic reporting

CMS proposal (p. 28256): CMS proposes to award bonus points for end-to-end electronic reporting of quality measures via EHR, registry, QCDR, or CMS Web Interface in the quality performance category. For each measure that is pulled from an EHR, the group or clinician would receive one point subject to a cap of 5% of the denominator.

MGMA comment: In addition to earning bonus points in the quality performance category, MGMA believes physicians and practices submitting quality measures via end-to-end electronic reporting should also earn full credit towards their ACI category. With MACRA, Congress set out to streamline and harmonize the current siloed quality reporting programs and we can think of no clearer way to satisfy congressional intent than to award credit across multiple MIPS performance categories for certain high-impact behavior. In fact, Congress specifically directed CMS to award credit across these two categories in Section 1848(q)(5)(B)(ii) of the statute, which provides that “with respect to a performance period for a year, for which a MIPS EC reports applicable measures under the quality performance category through the use of certified EHR technology (CEHRT), treat the MIPS EC as satisfying the clinical quality measures reporting requirement under section 1848(o)(2)(A)(iii) of the Act for such year.” Therefore, the agency should reconfigure the MIPS scoring methodology to permit cross-category credit for reporting quality measures via end-to-end electronic reporting.

When describing the overall direction of the program, CMS itself envisions a clinician or group practice using CEHRT to improve quality and reduce costs. On page 28184 of the proposed rule, CMS states, “[i]deally, clinicians in the MIPS program will have accountability for quality and resource use measures that are related to one another and will be engaged in CPIAs that directly help them improve in both specialty-specific clinical practice and more holistic areas (for example, patient experience, prevention, population health). Finally, MIPS ECs will be using CEHRT and other tools which leverage interoperable standards for data capture, usage, and exchange in order to facilitate and enhance patient and family engagement, care coordination among diverse care team members, and, in continuous learning and rapid-cycle improvement leveraging advanced quality measurement and safety initiatives.” CMS should make this vision a reality by recognizing that if a physician or practice is leveraging CEHRT to report quality measures, they are also demonstrating they are using the technology to capture, document, and communicate patient care information and should therefore receive both quality and ACI credit.

Quality performance benchmarks

CMS proposal (p. 28250): CMS proposes it will determine performance benchmarks for quality measures based on data from two years prior to the performance period. All MIPS ECs, regardless of specialty and whether they report as an individual or a group, that submit data using the same submission mechanism would be counted toward the same benchmark. CMS would include APM Entity submissions toward the benchmark, but would not score APM Entities using

this methodology. The agency plans to establish benchmark methodology in future rules and to publish numerical benchmarks “when possible” prior to the start of the performance period.

MGMA comment: MGMA recommends CMS use more recent data to establish measure benchmarks and urges the agency to publish these targets in advance of the performance period. To ensure a level playing field, groups and providers should know exactly what standards they are expected to achieve at the outset of the performance period. Without a target, physicians and group practices would essentially be resigned to blindly participating in another “black box” program that would not incentivize improvement. Shortening the performance period to 90 days would allow the agency far greater flexibility in establishing benchmarks based on more recent data and publishing them in advance of the start of a performance period.

Further, we oppose CMS’ proposal to establish a single benchmark for each reporting mechanism. Medical groups vary significantly based on size, location, and specialty, among a multitude of other factors, and practices should not be judged on a performance benchmark that fails to address these important differences.

MIPS resource use category

CMS proposal (p. 28196): CMS proposes to calculate a group’s resource use performance using Medicare administrative claims data, thus eliminating the need for data submission by ECs or groups. CMS would measure an EC’s or group’s resource use based on the total cost of care measure, Medicare Spending per Beneficiary (MSPB) measure, and applicable episode-based measures. Regarding the MSPB measure, CMS proposes to discontinue risk-adjusting for specialty mix and reduce the case minimum from 200 to 20 in order to apply it to a greater number of ECs and groups.

In response to feedback from MGMA and others, CMS proposes to calculate condition-specific costs based on episode-based measures for a variety of conditions and procedures that are high cost, rather than using the condition-specific total per capita cost measures under the VBPM that were not relevant to most practices. CMS would require a minimum of 20 cases to ensure reliability of episode groups and proposes to attribute acute condition episodes to ECs or groups that bill at least 30% of inpatient evaluation and management visits during the initial treatment or “trigger event” that opened the episode. The agency would then attribute procedural episodes to all MIPS ECs and groups that bill a Medicare Part B claim during the “trigger event” of the episode.

Section 1848(q)(5)(F) of MACRA permits CMS to weigh resource use as “not more than 10%” of a group’s MIPS total score in the first performance year and “not more than 15%” in the second performance year. CMS proposes to weigh resource use as 10% of a group’s first performance year score and 15% of their second performance year score.

MGMA comment: Using the Secretary’s authority under section 1848(q)(5)(F) of MACRA to assign different scoring weights, CMS should reweight the MIPS resource use performance category to zero until the agency has extensively tested the new episode-based measures, reformed the patient attribution methodology, and implemented key aspects of this category,

including patient relationship codes and risk-adjustment recommendations from the congressionally-mandated report by the ASPE. Additionally, CMS should eliminate cost measures from this category.

Although MGMA believes episode-based measures are a better way to measure resource use, the proposed measures are still being developed and have not been adequately tested to ensure that the attribution policies accurately illustrate the patient-provider relationship and have not been properly risk-adjusted to ensure that the measures do not penalize or discourage providers from treating atypical or chronically-ill populations. MGMA separately submitted [comments](#) regarding our ongoing concern that CMS has not adequately involved physicians in the measure development process.

In MACRA, Congress recognized patient relationship categories and codes are necessary to improve the accuracy of patient attribution by distinguishing services and items furnished based on the relationship between the patient and physician. However, CMS does not anticipate implementing the patient relationship categories and codes until at least Jan. 1, 2018, and CMS' policy proposals regarding the categories and codes are currently open for public comment.

ASPE is currently conducting a study on the issue of risk adjustment for socioeconomic status on quality measures and resource use as required by the Improving Medicare Post-Acute Care Transformation Act of 2014, but ASPE does not expect to issue its findings to Congress until October 2016. CMS admitted it would not have sufficient time to incorporate the highly-anticipated risk adjustment recommendations from ASPE ahead of the first MIPS performance period. Because development of these key aspects of the MIPS resource use category is still underway, MGMA strongly recommends that CMS use its authority to reweight the resource use performance category to zero until and the episode groups have been tested, CMS has implemented patient attribution codes, and the agency has reviewed and incorporated ASPE's risk adjustment recommendations.

Further, to hold clinicians responsible for resource use, including episode-based measures, CMS must provide timely and actionable information regarding these costs. We urge the agency to also consider delaying measurement of clinicians and groups on the resource use category of MIPS until it is operationally feasible to provide regular cost and attribution feedback on at least a quarterly basis.

Finally, CMS should eliminate the cost measures from this category. Episode groups are a more accurate way to measure resources and, it is unnecessary to maintain the MSPB and total per capita cost measures that were developed for hospital-level measurement. The cost measures used under the VBPM were irrelevant for many physicians, either because they had no patients attributed to them or because they had little opportunity to influence costs. Further, these cost measures negatively impacted providers who treat vulnerable patients with atypical or complex conditions. According to the 2015 VBPM Program Experience Report, CMS' own data demonstrates physicians treating the largest shares of Medicare's sickest patients were the most likely to incur downward adjustments under the VBPM.

If CMS must maintain the MSPB and total per capita cost measures, then the agency should, at a minimum, increase the sample sizes to ensure stronger statistical reliability and reinstate the specialty adjustment. Because CMS would calculate these measures using administrative claims data and groups and clinicians would not be required to actively report, there would be a very limited increase in administrative burden if the agency finalizes a resource use performance period longer than 90 consecutive days. MGMA recommends CMS identify the most appropriate length of analysis to ensure these measures are being evaluated using a statistically robust sample while also balancing the need to maintain consistency across the program and reduce the two-year lag between performance and payment.

MIPS advancing care information (ACI) performance category

The intent of the MACRA legislation was to create a harmonized program with simplified and flexible reporting requirements that apply to a broader range of clinicians in all sizes of practices and all medical specialties that achieves its original goal of improving the quality of patient care. Unfortunately, it is clear the proposed ACI component of MIPS has achieved none of these goals and is in need of significant modification.

We assert that the statute is clear in its delineation that a clinician must simply demonstrate they are a “meaningful user” of their EHR and does not in any way prescribe the highly complex and burdensome process proposed in this rule: “(D) *CONTINUED APPLICATION FOR PURPOSES OF MIPS.— With respect to 2019 and each subsequent payment year, the Secretary shall, for purposes of subsection (q) and in accordance with paragraph (1)(F) of such subsection, determine whether an eligible professional who is a MIPS eligible professional (as defined in subsection (q)(1)(C)) for such year is a meaningful EHR user (emphasis added) under this paragraph for the performance period under subsection (q) for such year.*”

MACRA instructs the Secretary of the Department of Health and Human Services (HHS) to involve stakeholders in the process of developing MIPS in order to design a program that is consistent with the legislative intent of the law. Public comments submitted in response to CMS’ Request for Information by MGMA and many other provider organizations made it abundantly clear that the program must be simplified, clinically relevant, and bear less of a reporting burden on physician practices.

Already, a significant percentage of private practice clinicians do not participate in the current Meaningful Use program. The proposed ACI requirements, which require ECs to successfully meet each base score objective or risk failing the entire category and then separately achieve high marks on a completely different set of performance score requirements (which are evaluated on an entirely distinct scoring scale) would only serve to further discourage clinicians from acquiring and using these important EHR technologies, and places providers in small and rural practices at an even greater disadvantage. Below, we offer several proposals that, if implemented, would assist the agency in achieving its stated goal of encouraging the adoption of effective EHR technology, while not making it difficult, if not altogether impossible, for smaller and rural practices to succeed.

Base score primary proposal

CMS proposal (p. 28221-28222): To earn points toward the base score, a MIPS EC must report the numerator and denominator of certain measures specified for the ACI performance category

MGMA comment: This base score is predicated on ECs employing 2015 CEHRT and also draws heavily from the widely criticized Stage 3 Meaningful Use final rule. As no EHR products are expected to be 2015 certified by January 2017, the agency is in fact forcing ECs to use the “alternate” base score approach, a repeat of the Modified Stage 2 Meaningful Use requirements. Further, despite the agency characterizing the ACI component of MIPS as “flexible” and “moving away from a pass-fail program design” in the rule itself, the base score is exactly that. As the rule states on page 28221: *“Failure to meet the submission criteria (numerator/denominator or yes/no statement as applicable) and measure specifications (as defined in section II.E.5.g.7. of this proposed rule) for any measure in any of the objectives (emphasis added) would result in a score of zero for the ACI performance category base score, a performance score of zero (discussed in section II.E.5.g. of this proposed rule) and an ACI performance category score of zero.”*

With the passage of MACRA and requirement to reconfigure the existing reporting programs, the ACI program presents an opportunity to design a truly flexible approach that would strongly encourage ECs and group practices to adopt EHR technology that could improve patient care and make the delivery of that care more efficient. Toward this, we recommend the base score and performance score approaches be combined into one simple and flexible program. The design should be as follows:

- The program would be comprised of two parts, a base score and a performance score.
- The base score would require the EC or group practice to attest they are using 2014 or 2015 CEHRT.
- For the initial 2019 payment year (proposed 2017 performance year), the ACI component score would be comprised solely of the EC’s or group practice’s attestation that they utilized 2014 or 2015 CEHRT during the reporting period.
- For the 2020 payment year, the base score would be worth 75% of the EC or group practice’s ACI component score.
- For the performance score, the EC or group practice would select five from a minimum of 17 objectives/measures that could include:

	Objective	Measure
1	Protect Patient Health Information	Conduct a Security Risk Assessment
2	Electronic Prescribing	ePrescribe (1 patient)
3	Coordination of Care Through Patient Engagement	Patient Access (Engaged)
4	Coordination of Care Through Patient Engagement	View, Download or Transmit (VDT) (1 patient)
5	Coordination of Care Through Patient Engagement	Secure Messaging (1 patient)

6	Coordination of Care Through Patient Engagement	Patient-Generated Health Data (1 patient)
7	Health Information Exchange	Patient Care Record Exchange (1 patient)
8	Health Information Exchange	Request/Accept Patient Care Record (1 patient)
9	Health Information Exchange	Clinical Information Reconciliation (1 patient)
10	Clinical Decision Support	CDS (Interventions, Drug Interaction and Drug-Allergy Checks Engaged)
11	Computerized Physician Order Entry	CPOE (Medication Orders, Lab Orders, Diagnostic Imaging Orders Engaged)
12	Patient Specific Education	PSE (1 patient)
13	Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting (Active Engagement)
14	Public Health and Clinical Data Registry Reporting	Syndromic Surveillance Reporting (Active Engagement)
15	Public Health and Clinical Data Registry Reporting	Electronic Case Reporting (Active Engagement)
16	Public Health and Clinical Data Registry Reporting	Public Health Registry Reporting (Active Engagement)
17	Public Health and Clinical Data Registry Reporting	Clinical Data Registry Reporting (Active Engagement)

- Performance objectives would be evaluated using an approach similar to the one proposed for the ACI base score in which ECs or groups would receive a full five points towards their 25-point performance score for successfully meeting the numerator and denominator reporting thresholds for each objective, so that reporting all five objectives would equate to a full 25% toward their performance score, reporting four would equal 20%, and so on.
- Alternatively, the EC or group practice would select five measures from the list above and be scored on their performance within each of the five measures, similar to Table 9 in the proposed rule.
- There would be no minimum required score and no required individual objectives or measures.

These modifications would not only reduce the burden on ECs and group practices, but also permit each EC and group practice to determine which objectives/measures would be most appropriate in relation to how they deliver care to their patients. Most importantly, this

methodology would also serve to better level the playing field between those practices with fewer resources and those with more.

Base score alternate proposal / base score modified primary and alternate proposals (Modified Stage 2 in 2017)

CMS proposal (p. 28223, 28224): Under the CMS alternate proposal for the base score of the ACI performance category, a MIPS EC would be required to submit the numerator (of at least one patient) and denominator, or a yes/no statement as appropriate, for every measure required for Stage 3 in the 2015 EHR Incentive Program Final Rule (80 FR 62829– 62871), as outlined in Table 7 of the proposed rule.

In connection with that proposal, and in an effort not to unfairly burden MIPS ECs who are still utilizing EHR technology certified to the 2014 Edition certification criteria in 2017, we propose, at § 414.1380(b)(4), modified primary and alternate proposals for the base score for those MIPS ECs utilizing EHR technology certified to the 2014 Edition. We note these modified proposals are the same as the primary and alternate proposals outlined above in regard to scoring and data submission, but vary in the measures required under the Coordination of Care Through Patient Engagement and Health Information Exchange objectives, as demonstrated in Table 8 of the proposed rule. This approach allows MIPS ECs to continue moving toward advanced use of CEHRT in 2018, but allows for additional flexibility in the implementation of upgraded technology and in the selection of measures for reporting in 2017.

MGMA comment: When CMS issued a final rule on Oct. 6, 2015 modifying many aspects of the problematic Stage 2 Meaningful Use regulation, it was concrete recognition that a significant number of clinicians were unable to meet the existing requirements. We believe it was also in response to concerns raised by MGMA, other provider associations, and numerous members of Congress that the Meaningful Use program was not achieving its stated goals and needed to be completely reconfigured. Further, Acting Administrator Slavitt, at several venues in the past few months, including his speech before the AMA House of Delegates on June 13, was very encouraging regarding the need for the agency to significantly restructure all reporting programs and in stating that the current Meaningful Use program would not be continued. With this as background, we were disappointed to find that the base score alternate and modified primary and alternate proposals were simply a repeat of current Meaningful Use requirements.

We urge the agency to completely do away with the Modified Stage 2 and Stage 3 Meaningful Use requirements and adopt a more workable, streamlined approach, as the statute intended. As discussed above, we recommend that the base score be reweighted to account for 100% of the total ACI performance score for the 2019 payment year, and to consist solely of an EC or group practice attesting to using 2014 or 2015 CEHRT. In 2020 and subsequent payment years, this attestation of CEHRT usage would comprise 75% of the total ACI component score, with the performance score accounting for the remaining 25%, where 5% would come from meeting the reporting threshold requirement for each of the five objectives.

Performance score

CMS proposal (p. 28224): In addition to the base score requirements, all of which a clinician would have to satisfy in order to not be scored a zero for the entire ACI category, he or she would then have to report a secondary set of performance measures, which collectively comprise half of the total ACI score.

MGMA comment: To receive additional ACI points beyond the base score, ECs and group practices would have to strive for significantly higher, yet unknown, thresholds in their performance score. There are currently eight such proposed measures (patient access, patient specific education, VDT, secure messaging, patient-generated health data, patient care record exchange request, accept patient care record, and clinical information reconciliation). Two of these measures, patient-generated health data and patient care record exchange, are not currently included in 2014 CEHRT and therefore the reporting options ECs and group practices would face in the performance score category would be significantly reduced. Further, five of the eight performance measures also force ECs/groups to rely on the actions of a third party (patient or other clinical setting) in order to be successful.

Table 9 in the proposed rule, which depicts an example of what a fictitious EC's performance score might look like, is perhaps unintentionally telling in that it records a high score in a category that is within the EC's control (95% for "patient access") and records a markedly lower score for categories that require third party action (i.e., 3% for secure messaging). In the final modification rule, published Oct. 6, 2015, the agency lowered the original Stage 2 view, download, transfer and secure messaging requirements from 5% to one patient, and having the capability, respectively, because many clinicians experienced substantial challenges in meeting these and other measures requiring third party action. We do not believe the healthcare environment has changed significantly enough to expect ECs and groups to achieve high scores in these categories.

In addition, certain practices, including smaller and rural practices or those of certain specialty designations, are inherently disadvantaged when it comes to achieving high scores for many of the ACI performance categories. For instance, medical specialties that traditionally do not have the type of relationship with the patient that would facilitate continued ongoing patient communication (i.e., a specialist who might see a patient only one time for a consult) would struggle to achieve high scores. Similarly, smaller, or more rural ECs and group practices often do not have the same financial and technology capabilities as larger practices to engage patients and other clinical sites through HIT. It is patently unfair that being a practice with fewer resources significantly increases the penalty risk under MIPS.

Data blocking attestation

CMS proposal (p. 28165, 28171): CMS proposes to require MIPS ECs, as well as ECs and group practices, eligible hospitals, and Critical Access Hospitals (CAHs) to demonstrate to not blocking the sharing of information under section 106(b)(2) of MACRA.

CMS proposes requiring ECs, eligible professionals (EPs), eligible hospitals, and CAHs to attest they have cooperated in good faith with surveillance and direct review of their HIT certification by ONC, as authorized by 45 CFR part 170, subpart E. Under the proposed terms of attestation, such cooperation would include responding in a timely manner and in good faith to requests for information (for example, telephone inquiries, written surveys) about the performance of the CEHRT capabilities in use by the provider in the field.

The provider's cooperation would also include accommodating requests (from ONC authorized certification bodies or from ONC) for access to the provider's CEHRT (and data stored in such CEHRT) for the purpose of carrying out authorized surveillance or direct review, and to demonstrate capabilities and other aspects of the technology that would be the focus of such efforts, to the extent that doing so would not compromise patient care or be unduly burdensome for the EC, EP, eligible hospital, or CAH. CMS cites in the proposed rule that it understands that cooperating with in-the-field surveillance may require prioritizing limited time and other resources.

MGMA comment: We understand the intention of this requirement and applaud the government for seeking to reduce the number of data blocking occurrences and increase surveillance of EHR products. However, we assert that EC attestation as a requirement of MIPS participation is not the appropriate vehicle for achieving this goal. ECs, especially those in smaller practices, have little or no influence over the actions their EHR vendor takes, nor do they typically have insight into the data sharing policies of vendors or downstream provider organizations. As with each of the MACRA regulatory requirements, ECs and group practices should only be responsible for the actions that they have direct control over. One additional challenge is effectively defining "data blocking." For example, a provider who cannot afford interface technology should not be deemed guilty of data blocking.

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

2015 CEHRT requirement

CMS proposal (p. 28219): Beginning with the performance period in 2018, MIPS ECs must use technology certified exclusively to the 2015 Edition in order to meet the objectives and measures specified for the ACI performance category in section II.E.5.g.7. of the MIPS/APM proposed rule, which correlates to Stage 3 of Meaningful Use. CMS solicits comments on this proposal.

MGMA comment: Mandating ECs use 2015 CEHRT in 2018 is unacceptable. As of this writing, the ONC's Certified Health Products Listing does not contain a single EHR product that has been certified as meeting the 2015 certification requirements. CMS is assuming that the 774 complete EHR products currently available for use in ambulatory settings will all be recertifying to meet the more stringent 2015 criteria, within one year no less. EHR vendors are not required by law to recertify and MGMA remains extremely concerned that a significant percentage of the

currently-certified products will not be recertified to this higher standard, given the substantial costs associated with development, testing and rolling out to customers. Furthermore, the cost to practices of purchasing the new software and retraining staff would be significant, thus almost certainly disproportionately impacting smaller practices who are less likely to have the resources to purchase expensive new EHR products in the first place, and if they do are more likely to purchase from smaller, more cost-effective vendors least likely to recertify to meet the 2015 requirements, especially by 2018.

For the reasons stated above, we recommend 2014 CEHRT be permitted for the 2017-2020 performance years at a minimum, and that ONC be required to issue an annual report, detailing the number of compete ambulatory EHR products that have been recertified to meet the 2015 requirements. Then, only once it has been determined that a large majority of these products have been recertified should 2015 CEHRT be required for EC reporting.

Security RA

CMS proposal (p. 28221): CMS proposes that a MIPS EC must meet the protect patient health information objective and measure in order to earn any score within the ACI performance category.

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

On the issue of encryption, it is important to remember this method of protecting patient data is an “addressable” issue under the HIPAA Security rule. We encourage CMS to work with the Office for Civil Rights on the development of guidance and educational materials to assist physician practices in understanding and implementing encryption, should it be determined by the practice to be an appropriate solution.

An additional challenge to this objective has been the imprecise definition of “risk analysis.” The HIPAA security regulation outlines the process an organization must go through, but does not specify the exact steps, milestones or expected outcomes of that analysis. Consequently, compliance with this requirement and fulfillment of this current Meaningful Use objective has proven difficult, especially for smaller practices that typically have limited in-house expertise in this area.

CMS should also work with OCR to develop guidance and education on the issues of risk analysis and mitigation. In particular, we would encourage full transparency from those agencies that conduct audits of practice security processes and procedures. Having CMS (Figliozi), OCR, and the Office of Inspector General provide comprehensive details of each of its audit processes and de-identified findings would be helpful for practices seeking to better understand the government’s risk analysis requirements.

We further recommend CMS provide physician practices with guidance on the various available security frameworks and how to implement them, so electronic protected health information is protected with administrative, physical and technical safeguards (as required under HIPAA). While many security frameworks exist, the healthcare industry has not reached consensus in terms of a single approach. Practices need to have a clear benchmark for understanding the requirements in all of these areas to ensure they have implemented an adequate security infrastructure.

View, download or transmit (VDT) and secure messaging (SM)

CMS proposal (p. 28227-28229): As proposed for the VDT measure, at least one unique patient (or patient-authorized representative) seen by the EC during the performance period must actively engage with the EHR made accessible by the EC. The EC may meet the measure by either—(1) viewing, downloading or transmitting the patient’s health information to a third party; or (2) accessing of the patient’s health information through an application program interface (API); or (3) a combination of (1) and (2).

Use certified EHR technology to engage with patients or their authorized representatives about the patient’s care. **SM Measure:** For at least one patient seen by the MIPS EC during the performance period, an SM was sent using the electronic messaging function of certified EHR technology to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient authorized representative) during the performance period.

MGMA comment: MGMA members have reported experiencing significant challenges in attempting to meet the Stage 2 VDT and SM requirements. Not only are there technical hurdles to overcome before the practice can deploy a patient portal that is both convenient for the patient and securely protects data, but an overwhelming percentage of patients never take advantage of (VDT or secure messaging) functionalities. Including unworkable measure thresholds at the onset will only discourage ECs and group practices from participating in the MIPS program altogether, causing a severe blow to the program achieving widespread participation and achieving its goals in the long-term. Significantly reducing the VDT reporting threshold from 5% to one patient and the SM requirement from 5% to simply having the capability in the modifications rule less than one year ago is a direct recognition that ECs and group practices were generally unable to meet the thresholds. Because of this, at this point in the program we recommend VDT and SM be optional for ECs participating in MIPS.

We make this recommendation in recognition that numerous medical specialties may not have an ongoing relationship with a patient that necessitates access to the medical record or electronic messaging through a web portal. Following what could be a short consultation with the EP, it has proven to be highly unlikely the patient would subsequently create an account and log into a portal to view, download, or transmit their medical record or send a secure message. Further, with ECs and group practices providing the patient with a summary of the visit, it makes it unlikely the patient would leverage a web portal to access what could be the exact same information. In addition, the recently revised HIPAA Privacy regulations already require providers make available to the patient their record in an electronic format, rendering this

particular requirement not only unrealistic, but redundant.

While we may agree that as technology improves, patients are becoming more engaged in their healthcare, the industry is clearly not at the stage to support arbitrarily high thresholds for VDT and SE, particularly for the Medicare population. It is true that more and more patients want to leverage online functionalities when interacting with the healthcare system. However, our members report that patients are far more interested in utilizing other online administrative tools, such as appointment scheduling, prescription refill requests, reviewing and paying outstanding balances, completion of registration information, the HIPAA acknowledgement of receipt of the practice's Notice of Privacy Practices, insurance-related information, and other required forms. Should the agency require any threshold, we strongly recommend these administrative transactions be permitted to count toward the numerator, including those that occurred prior to, or in lieu of, a face-to-face visit with the EP. By incentivizing and rewarding practices for encouraging patients to use this wider variety of online administrative services, it would be much easier to simultaneously encourage patients to also view, download or transmit their record or access SM features, thereby achieving higher levels of patient involvement all-around.

Health information exchange (summary of care) measure

CMS proposal (p. 28228): Under the proposed Health Information Exchange measure, ECs would be required to use 2014 CEHRT to create the summary of care record and send these care summaries “electronically” to a receiving provider, as they are required to do now under Stage 2.

MGMA comment: MGMA has concerns regarding what would constitute an acceptable “electronic” transmission. Recognizing that each transmission method may require the practice to reconfigure workflows, we recommend CMS develop clear guidance to assist ECs in clearly understanding transmission options at the onset of the performance period.

Additionally, we concur with the agency's earlier contention that opening up the measure for alternative electronic delivery pathways could reduce administrative expense for ECs seeking to meet this measure, though we do not believe this flexibility will completely eliminate EC costs. We urge the agency to monitor EC transmission costs and burdens and modify this measure should the evidence suggest ECs are being subjected to overly expensive or burdensome processes.

ECs facing a significant hardship

CMS proposal (p. 28232):

CMS believes that under their proposals for the ACI performance category, there may not be sufficient measures applicable and available to MIPS ECs within the categories below.

1. The lack of availability of internet access or barriers to obtain IT infrastructure.
2. A time-limited exception for newly practicing ECs and group practices or new hospitals that would not otherwise be able to avoid payment adjustments.
3. Unforeseen circumstances such as natural disasters that would be handled on a case-by-case basis.

4. (For ECs and group practices only) Exceptions due to a combination of clinical features limiting a provider's interaction with patients or, if the EC practices at multiple locations, lack of control over the availability of CEHRT at practice locations constituting 50% or more of encounters.

For these MIPS ECs, the agency proposes to rely on section 1848(q)(5)(F) of MACRA to re-weight the ACI performance category to zero.

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

- Concerning the lack of available internet access exception, CMS should publish a definitive explanation for what constitutes "limited access" and provide a list of all counties that have been identified by the Federal Communications Commission, or another agency, as having limited internet access.
- Expand the hardship exception for ECs and group practices who experience unforeseen circumstances that render it impossible to demonstrate the ACI requirements during the reporting period through no fault of their own to a minimum of five years after they begin experiencing these circumstances.
- Add a new hardship exception for ECs and group practices who have switched from one EHR product to another, or experience significant difficulties with their EHR.
- Similarly, should a software product be decertified, the EC or group practice should not be held accountable for irresponsible actions on the part of the vendor. It is also unreasonable to expect an EC who has purchased an EHR that was subsequently decertified to immediately purchase a new system. We recommend CMS establish a minimum 24-month hardship exception for any EC who has had to replace their system or had their EHR decertified.
- Expand the hardship exception for ECs and group practices practicing for a limited period of time to allow them the additional time to identify, acquire and implement the most appropriate EHR technology. In addition, we recommend the exception be expanded to include those ECs and group practices who have changed specialty taxonomy.
- Remove any time-limits (imposed under the current Meaningful Use program) from exceptions granted to certain medical specialties (Anesthesiology, Radiology, and Pathology) who do not typically have face-to-face encounters with patients. Should an EC qualify for this "specialty exception," it will be because they do not have the ability to participate in ACI based on current technological capabilities and program requirements. While we agree that there will likely be advancements in the areas of CEHRT and health information exchanges, it is unlikely that these advancements will materially alter the environment in which these ECs and group practices practice and these can always be

addressed with future rulemaking.

- Grant older ECs eligible for Social Security benefits a hardship exception and have them not be subject to any Medicare payment adjustment. Meeting the ACI requirements requires considerable expenditures of both human and financial capital and it is expected that the return on investment of an EHR installation to support MIPS will require several years of operation.
- Simplify the hardship exception application process by permitting multiple application submission options, including mail, fax and online capabilities. This would allow ECs and group practices additional flexibility for submitting applications.
- Extend the time period in which ECs and group practices can submit hardship exceptions from July 1 to Dec. 31 of the reporting year. We contend that a full six months is not required to capture the data and determine what ECs and group practices would be subject to the penalty. As a reference point, CMS permitted ECs and group practices to submit a hardship request via a web-portal tool until Nov. 8, 2011 for the 2011 E-prescribing Incentive Program.
- Provide email receipt confirmation once a hardship application has been submitted by an EP. This would avoid the situation that some of our members have encountered, where they find out only after the hardship exception deadline has passed that the application was never officially received by CMS.

Reweighting of the ACI performance category for MIPS ECs without sufficient measures applicable and available hospital based ECs

CMS proposal (p. 28230, 28231): CMS proposes to rely on section 1848(q)(5)(F) of MACRA to assign a weight of zero to the ACI performance category for hospital-based MIPS ECs. CMS proposes to define a “hospital-based MIPS EC” at § 414.1305 as a MIPS EC who furnishes 90% or more of his or EHR covered professional services in sites of service identified by the codes used in the HIPAA standard transaction as an inpatient hospital or emergency room setting in the year preceding the performance period, otherwise stated as the year three years preceding the MIPS payment year. For example, under this proposal, hospital-based determinations would be made for the 2019 MIPS payment year based on covered professional services furnished in 2016. CMS also proposes, consistent with the EHR Incentive Program, that CMS would determine which MIPS ECs qualify as “hospital-based” for a MIPS payment year.

MGMA Comment: We agree hospital-based ECs, as defined in the proposed rule, should be assigned a weight of zero for the ACI component of MIPS.

Hospital based ECs in the future

CMS proposal (p. 28231): CMS seeks comment on how the ACI performance category could be applied to hospital-based MIPS ECs in future years of MIPS, as well as the types of measures that would be applicable and available to these ECs.

The agency also seeks comment on whether the previously established 90% threshold of payments for covered professional services associated with claims with place of service (POS) codes 21 (inpatient hospital) or 23 (emergency department) is appropriate, or whether CMS should consider lowering this threshold to account for hospital-based MIPS ECs who bill more than 10% of claims with a POS other than 21 or 23.

MGMA Comment: We assert there are insufficient measures applicable and available to hospital-based ECs under the current proposals for the ACI performance category of MIPS. Hospital-based ECs typically do not have control over the decisions the hospital makes regarding the use of CEHRT. These ECs therefore may have no control over the type of CEHRT available, the way that the technology is implemented and used, or whether the hospital continually invests in the technology to ensure it is compliant with ONC certification criteria. In addition, some of the specific ACI performance category measures, such as the patient access measure under the patient electronic access objective, requires that patients have access to view, download or transmit their health information from the EHR made available by the healthcare provider, which in this case would be the hospital. Therefore, the measure would be attributable and applicable to the hospital which controls the availability of the EHR technology, not the EC.

The requirement under the protect patient health information objective to conduct a security risk analysis would also force ECs to rely on the actions of the hospital, rather than those of the ECs themselves, as the hospital controls not only the access, but the implementation of the EHR technology. In this case, the measure is again more attributable and applicable to the hospital than to the MIPS EC.

Further, certain specialists (such as pathologists, radiologists and anesthesiologists) who often practice in a hospital setting and may be hospital-based ECs often lack face-to-face interaction with patients, and thus may not have sufficient measures applicable and available to them. For example, hospital-based ECs who lack face-to-face patient interaction may not have patients for which they could transfer or create an electronic summary of care record.

In terms of whether the previously established 90% threshold of payments for covered professional services associated with claims with POS Codes 21 or 23 is appropriate, we recommend the agency not decrease the threshold any lower than the current level, but rather impose a threshold of 75%. This would recognize that ECs who have a significant number of inpatient encounters should not be required to participate in a program designed for outpatient settings.

Further, as consistent with our other recommendations, we urge the agency to be transparent and give ECs advance notice at the start of the performance year regarding what time period will be used to determine whether the EC would be classified as inpatient, so that ECs may know in

advance whether or not they are required to participate in MIPS and do not waste resources and time reporting unnecessarily. We have heard from members who report that practice ECs who were well above the 90% threshold for the majority of the previous two years were unfairly penalized because the agency selected a seemingly arbitrary time period and the EC was consequently deemed under the 90% threshold.

Issue: Vendor readiness

MGMA comment: Assuming this regulation is finalized in the last quarter of 2016, as the acting administrator has suggested, we are very concerned that physician practices and their EHR vendor partners will have insufficient time to implement these changes and prepare to begin reporting in time to meet the Jan. 1, 2017 start date. It is important to remember that as the rule is proposed, vendors would not be required to adopt the most up-to-date certification requirements. A recent review of the ONC Certified Health IT Product List shows that there are currently 774 complete EHR products for ambulatory use certified under the 2014 requirements, but none are listed as being certified to meet the 2015 certification requirements. While ECs under the proposed rule do have the option of using 2014 CEHRT to compile their ACI score in 2017, by 2018 all ECs would be required to be using 2015 CEHRT. This would force major technology upgrades that would require significant financial and human resource expenditures by clinicians. We are also concerned that some of the smaller EHR vendors may be delayed in upgrading their products to meet the 2015 CEHRT requirements, or may decide not to upgrade at all. These vendors are more likely to be servicing smaller physician offices who then would, at great expense and burden, be forced to replace their current technology.

We recommend adding flexibility to the CEHRT requirements by permitting 2014 CEHRT to be used by ECs in meeting the ACI requirements for several additional years. ONC should be solely responsible for monitoring the EHR vendor's transition from 2014 CEHRT to 2015 CEHRT. No EC should be required to use 2015 CEHRT to meet ACI reporting unless a n overwhelming number of 2014 CEHRT products have been recertified to the 2015 certification requirements.

Issue: Continued monitoring of the EHR marketplace

MGMA comment: Section 3007 (a) of the American Recovery and Reinvestment Act states: "The National Coordinator shall support the development and routine updating of qualified EHR technology ...and make available such qualified EHR technology unless the Secretary determines through an assessment that the needs and demands of providers are being substantially and adequately met through the marketplace."

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

We recommend that CMS, in partnership with ONC, continue to aggressively and comprehensively monitor the industry to ensure that: (a) there are a sufficient number of certified

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

MIPS clinical practice improvement activities (CPIA) performance category

CPIA measures and reporting

CMS proposal (p. 28210): CMS proposes ECs and groups may submit CPIA data using a qualified registry, EHR, QCDR, CMS Web Interface or attestation. “If technically feasible, [CMS] will use administrative claims data to supplement the CPIA submission.” For the first year, CMS proposes that “all MIPS ECs or groups, or third party entities such as health IT vendors, QCDRs, and qualified registries that submit on behalf of a MIPS EC or group, must designate a yes/no response for activities on the CPIA Inventory.” CMS proposes that MIPS clinicians and groups must perform CPIAs for at least 90 days during the performance period. Although in responding to the request for information, MGMA and “the majority of comments indicated that all subcategories should be weighted equally,” CMS proposed to weigh activities differently, assigning scores of 20 points to certain “high-level” activities and 10 points to “medium-level” activities.

MGMA comment: MGMA appreciates CMS’ proposal to give medical groups and providers 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, and we are pleased that many of these activities are included in the proposed CPIA inventory. However, we recommend CMS expand the high-weighted activities. There are numerous resource intensive and high-quality activities that are listed as only medium weight. We advise the agency to work closely with the appropriate medical specialties to reevaluate whether the appropriate weight was assigned to each CPIA when factoring in considerations such as time commitment, effort, and patient benefit.

We support the agency’s decision to base CPIAs on completion or ongoing participation, rather than hours devoted and generally agree that a 90-day performance period is a reasonable timeframe for demonstrating performance in these activities. We also agree that a yes/no attestation is a flexible and simple methodology for reporting these activities and we support CMS’ proposal to permit transmission of activities through registries, EHR vendors, and QCDRs where feasible.

CPIA performance scoring

CMS proposal (p. 28265): In general, to achieve the full CPIA score, CMS proposes that ECs and groups must submit a combination of high-weighted and medium-weighted CPIAs to achieve a total of 60 points. CMS proposes small groups (consisting of 15 or fewer ECs) and ECs and groups in rural areas or health professional shortage areas would receive full credit for reporting any two CPIAs (either high- or medium-weighted). ECs and groups participating in an APM would receive 50% of the total CPIA score (30 points) and those designated as medical homes by a national accrediting body would receive 100% of the total CPIA score (60 points). On this point, CMS specifically seeks comment on how to provide credit for PCMH accreditation when the designation only applies to a portion of the TIN. Finally, the agency proposes ECs and groups that volunteer to participate in CMS' *Study on CPIA and Measurement* would also receive 100% of the total CPIA score (60 points).

MGMA comment: MGMA urges CMS to reduce the number of required activities in this category. As proposed, physicians and groups could be required to report on as many as six different activities in order to receive the full CPIA score. While the activities vary in time and resources, six different requirements quickly add up and may become overly burdensome. Therefore, CMS should reduce the requirement to three activities, while allowing clinicians and group practices to report additional CPIAs at their discretion. Again, MGMA reminds CMS that CPIA is one of four components of MIPS, which, as proposed, would require clinicians and group practices to report on a minimum of 20 separate measures and objectives. We encourage the agency to allow practices to prioritize their quality improvement activities by requiring reporting on fewer measures across the MIPS performance categories, specifically decreasing the maximum required CPIAs from six to three.

MGMA supports CMS' proposal to allow small, rural, and non-patient facing practices to earn full credit for performing any two activities. We believe CMS should finalize this proposal and look for additional ways to ensure an even playing field in MIPS, especially given the government's own economic analysis in Table 64 predicts that MIPS will disproportionately penalize small and medium sized practices.

MGMA also supports CMS' proposal to award full CPIA credit to PCMHs that have been accredited by one of four national certifying bodies, as well as the patient-centered specialty recognition by the National Committee for Quality Assurance. MGMA encourages CMS to continue to look to the private sector for new opportunities to recognize emerging medical homes, particularly for specialty options, for which MGMA members have expressed interest. In general, however, as noted in our later comments, we believe CMS should be far more inclusive of medical homes in its Advanced APM definition.

However, we were disappointed CMS did not propose to award full CPIA credit to APM participants. MGMA urges CMS to award full CPIA credit for participation in an APM, as success in risk-based payment models requires practices to work towards a significant number of the proposed CPIAs in order to shift their focus from volume to value. Additionally, we believe the statute affords CMS the flexibility to grant full CPIA credit, as section 1848(q)(5)(C)(ii) of MACRA provides that participants in an APM must earn *at least one half* of the highest potential

score for the CPIA performance category. Therefore, CMS is well within the bounds of the law to award more credit, and MGMA believes CMS should award full credit for groups and physicians that are participating in an APM. Further, the definition of an APM under MIPS should not be limited to Advanced or MIPS APMs, but should incorporate participation in any APM, including those sponsored by a commercial payer, state government agency, or Medicaid.

Finally, echoing our sentiments earlier in this letter, we strongly encourage the agency to find every opportunity to award credit across the MIPS performance categories to achieve CMS' goal of establishing a patient-centric, streamlined, and flexible program that "wins back the hearts and minds of physicians." There are a number of proposed CPIAs that have a quality focus, such as diabetes screening for people with schizophrenia or bipolar disease. Groups and clinicians that engage in these activities should receive credit in both the CPIA and quality categories of MIPS. Similarly, there are CPIAs that have a focus on ACI, including using EHRs to capture additional data on behavioral health population and leveraging that information in clinical decision-making. MGMA recommends CMS award credit in both the CPIA and ACI categories for these overlapping activities.

CPIA policies for future years of the MIPS program

CMS proposal (p. 28214): CMS proposes criteria for adding new CPIAs and CPIA subcategories in future years. Specifically, the agency would limit new CPIA subcategories or activities based on whether "the new subcategory represents an area that could highlight improved beneficiary health outcomes, patient engagement and safety based on evidence; the new subcategory has a designated number of activities that meet the criteria for a CPIA activity and cannot be classified under the existing subcategories; and newly identified subcategories would contribute to improvement in patient care practices or improvement in performance on quality measures and resource use performance categories."

MGMA comment: MGMA opposes CMS' narrow requirements for adopting new CPIA initiatives in future years. MGMA reiterates our position that CMS must define CPIA in the broadest terms possible so as not to create another mechanism that prioritizes reporting over patient care. We urge CMS to view the CPIA inventory as fluid and to formalize a standard process through which the agency adds new activities each year as technology advances and practices find new and innovative ways to improve patient care.

MIPS composite performance score

MIPS scoring system

CMS proposal (p. 28249): CMS proposes to establish unique performance standards for each category of MIPS. Generally speaking, for the quality category, CMS would compare each measure against an established benchmark to assign points based on performance using decile scales and then add bonus points. For the resource use category, CMS would compare each measure against an established benchmark to assign points using decile scales. For the CPIA category, CMS would assign points that vary in value from 10 to 60 for completion of activities. For the ACI category, CMS would score performance on two distinct standards. The base score

would account for half of the overall ACI score and be based on all-or-nothing credit met by reporting the numerator and denominator or a yes/no statement for each required measure. The performance score would comprise the latter half, and assign points for performance above the base score using decile scales, similar to the scoring methodology of quality and resource use. Importantly, the agency also proposes a unique maximum score for each individual category, which range from 60 points to 131 points.

MGMA comment: Simply put, the proposed scoring system is nothing short of a mathematical marvel comprised of four complex formulas that are unified only in that they each contribute to the group's composite performance score. CMS must simplify and synchronize the scoring standard to ensure physicians and groups understand how they are being evaluated and scored and to uphold the intent of MIPS to harmonize the different reporting and scoring criteria under the current quality reporting programs. For example, the agency should establish an intuitive and uniform maximum number of points per category, such as 100. Additionally, the agency should adopt MGMA's recommendations to simplify MIPS as these would inherently improve the CPS. In summary, we have recommended the agency reduce the total number of quality measures to three, eliminate the population health and cost measures, simplify the ACI requirements, and decrease the number of required CPIAs.

CMS should also conduct extensive outreach and education about the scoring system. Physicians and group practices cannot be expected to take a back seat and allow CMS to conduct this overwhelmingly complex analysis, as it could significantly impact their payments. This "black box" scenario would immediately undermine trust in this new program and would likely lead many to opt out of MIPS entirely. Rather, the agency should partner with MGMA and other physician specialty organizations to provide robust and transparent provider education about the MIPS scoring standard.

Measuring performance improvement

CMS proposal (p. 28248): CMS would not evaluate clinicians and group practices on improvement in the first performance year of MIPS. To determine how best to measure improvement in future years, CMS seeks comments on three proposed alternatives for how to implement an improvement component of MIPS scoring in year two and beyond. The first option would assign 1-10 points for achievement and 1-9 points for improvement for each measure and use the higher of the two scores. Under the second option, clinicians and groups would receive up to four bonus points for their net performance improvement, similar to the scoring of improvement in the Shared Savings Program. Under the third option, CMS would calculate an overall improvement score and include it in the clinician's final quality score only if it is higher than the score without it.

MGMA comment: MGMA supports CMS' decision not to base MIPS scoring on performance improvement at the outset of MIPS. Although section 1848(q)(5)(D)(ii) of MACRA requires CMS to *consider* historical performance standards, it stops short of requiring the agency to actually *use* historical standards. The legislative intent is not to base this future program on current, flawed program standards. The most likely vehicle for that would be the VBPM, however a large percentage of physicians do not provide primary care practices and thus do not

have a VBPM score, and of those that do, there is widespread commentary that the flawed scores often bear little to no relevance to the practice's own performance. Given the imperfect and still-changing nature of the current programs, it is preferable to start fresh and use some future year as the basis for determining what constitutes "historical" performance. That said, we strongly encourage CMS to test each of the proposed methodologies in the physician practice environment before introducing them in MIPS.

Further, scoring based on improvement raises the issue of reducing the current two-year gap between performance and payment, which would make it extremely difficult to accurately gauge performance, as group practices operate in a fluid environment of recruitment, acquisition, expansion, and reduction. Even if the group remains identical between the performance and payment years, CMS would not reveal how the group can improve for two years – a gap that does not allow for actionable changes to drive improvements. Abundant education and outreach regarding improvement scoring is paramount to the success of the program, so that groups and providers know exactly what standards they are expected to achieve.

Risk adjustment

CMS proposal (p. 28268): The statute requires CMS to consider risk factors in the MIPS scoring methodology. ASPE is currently conducting studies and making recommendations on the issue of risk adjustment for socioeconomic status on quality measures and resource use, as required by the IMPACT Act, and expects to issue a report to Congress by October 2016. CMS plans to review recommendations and incorporate them as appropriate through future rulemaking.

MGMA comment: MGMA strongly advocates that CMS expeditiously and generously implement risk adjustment recommendations to ensure benchmarking and scoring methodologies do not penalize or discourage providers from treating atypical or chronically-ill populations. Due to significant variability between medical specialties, practices should not be judged on an arbitrary performance thresholds or benchmarks unless they are appropriately specialty and subspecialty-specific risk-adjusted. Finally, as previously discussed, we recommend CMS reweight the resource use category to zero until the agency has time to incorporate ASPE's risk adjustment recommendations, among addressing other concerns with the methodology.

Reweight the performance categories

CMS proposal (p. 26269): The statute directs the Secretary to assign different scoring weights for performance categories where there are not sufficient measures and activities applicable and available to each type of EC involved. In general, CMS proposes to reassign the scoring weights for categories that cannot be evaluated to the quality performance category. However, if a physician or group receives a score for only one performance category, CMS proposes to assign a score equal to the performance threshold, which translates to a MIPS payment adjustment of zero.

MGMA comment: MGMA is concerned about CMS' proposed approach of primarily increasing the impact of the quality score when a physician or group cannot report certain MIPS

categories. We urge CMS to give physicians and groups the option to choose to increase the weight of the CPIA category, as most clinicians and groups would be able to find relevant CPIAs for their practice.

Performance thresholds

CMS proposal (p. 28273): CMS proposes that CPS scores above the performance threshold would receive a MIPS bonus, while CPS scores below the performance threshold would receive a penalty, with CPSs falling between zero and one-fourth of the performance threshold receiving the maximum MIPS penalty. For the first payment year, CMS intends to set the performance threshold so that approximately half of the ECs would fall below, and half above.

In addition, CMS would establish a higher “exceptional performance” threshold for earning a bonus. The agency proposes to use one of the following methods to compute this benchmark: (1) the threshold would be equal to the 25th percentile of the range of possible CPSs above the performance threshold, or (2) the threshold would be equal to the 25th percentile of the actual CPSs at or above the performance threshold. CMS intends to publish this exceptional performance threshold along with the performance threshold prior to the performance period.

MGMA comment: MGMA urges CMS to consider the government’s own economic projections contained in Table 64 when finalizing the performance threshold calculations, which predicts MIPS will disproportionately penalize small and medium sized practices. Because this analysis is based on 2014 PQRS reporting, the agency contends this analysis presumes that small and medium-sized practices opted out of participating, thus defaulted and faced a penalty, but that this would not be the case in MIPS. However, there is nothing in this proposed rule to indicate that this dynamic would change, as many practices with less administrative and financial resources are likely to opt out of MIPS particularly in this first performance year due to program complexity and reduced financial downside. Practices currently face penalties of up to 11% for failing to satisfactorily report in PQRS, Meaningful Use, and the Value-Based Payment Modifier. However, the first performance period in MIPS will be tied to a maximum penalty of 4%. Should CMS refuse to acknowledge this consistent pattern, we will continue to see results similar to the 2015 VBPM adjustment factor, in which a handful of sophisticated group practices received a windfall because thousands of smaller groups with less infrastructure support either could not or chose not to participate in PQRS.

MIPS Feedback Reports

Frequency of feedback

CMS proposal (p. 28276): CMS proposes to provide annual MIPS feedback reports to ECs and groups starting July 1, 2017. For APM entities, the agency would provide performance feedback “as technically feasible.”

MGMA comment: MGMA’s long-standing position is that CMS should provide ongoing, real-time measurement and performance feedback to all impacted physicians and group practices. Equipped with this data, practices would be able to understand their past performance, identify

potential areas for improvement, and make necessary adjustments to successfully participate in MIPS. Annual feedback, typically provided months after the performance period has ended, provides physician groups no recourse to respond during the performance period. Further, annual feedback has minimal applicability to future performance, as the program rules regularly shift between performance periods and the health care landscape is rapidly evolving. At a minimum, the agency should meet the congressional recommendation of providing feedback on a quarterly basis to physicians and group practices, regardless of whether they are participating in an APM.

Content and access to feedback reports

CMS proposal (p. 28276): CMS proposes to use PECOS contact information to notify ECs and groups when their performance feedback is available, which would be accessible via a CMS designated system, such as a web portal or interactive dashboard if feasible. CMS would provide annual feedback reports similar to QRURs which would include data on quality and resource use, but not ACI or CPIA. The agency is considering using dashboards and health IT vendors to help make the reports more accessible and useful. The agency also intends to “establish resources, such as a helpdesk or offer technical assistance, to help address questions with the goal of linking these resource features to the CMS designated system.”

MGMA comment: MGMA agrees with CMS that physicians and group practices must be individually notified when their performance feedback is available and appreciates that CMS proposes to utilize existing contact information in PECOS for this purpose. However, we urge CMS to go further than simply notifying practices their feedback is available. The agency should take this opportunity to thoroughly educate physicians and practice administrators about how to access these new reports, which should be available through a variety of mediums, including but not limited to dashboards and paper reports. With technology constantly changing, it is critical CMS take an ongoing approach to improving the way performance information is disseminated to physicians and practices.

MGMA is disappointed the agency did not disclose details about how it plans to improve the log-in process for accessing feedback reports via the web portal. There have been ongoing problems with accessing QRURs 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. In order for practices to actively leverage the information in their MIPS performance reports to improve quality of care in their practices as intended, the log-in process for accessing these reports must be simple and user-friendly. Additionally, to improve overall efficiency and actionability, feedback reports should be made accessible to physicians, practice administrators, or other individuals, as delegated by the physician.

MGMA is concerned over CMS’ proposal to use QRURs as a template for the MIPS performance feedback reports. Although we acknowledge CMS has made refinements to the QRURs based on provider feedback, these reports continue to confound providers and groups who need to understand the information to configure and improve clinical and administrative management systems and office protocols. For instance, MGMA members have shared concerns that they are unable to process and utilize the QRURs, which are upwards of 70 pages long and filled with CMS jargon, complex explanations, and unfiltered data.

We recommend CMS work closely with providers and practice administrators to ensure the feedback reports 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. The reports should provide both high-level overview information that provides practices with a helpful snapshot of their performance, how they compare to their peers across the country, perhaps aggregated by practice size and/or specialty, and targetable areas for improvement, but also the ability to drill down to more detailed practice-level and physician-level performance information, so that practices can delve deeper into a particular area they interested in targeting for future improvement efforts.

Finally, we urge CMS to prioritize its education and outreach efforts and develop more timely resources that educate providers and practice staff to help them understand feedback well enough to translate the information into meaningful improvements in their practices. MGMA members have informed us the assistance provided by the QualityNet Help Desk has been inconsistent and, at times, unhelpful. We urge the agency to properly train QualityNet Help Desk staff and other contractors about the technicalities of feedback reports and how to utilize the information and data to evaluate past performance and to improve moving forward. Reducing complexity of the program would make it easier for contractors to offer more expert, tailored insight to practices, and also likely reduce the traffic of questions and concerns outright. Additionally, CMS staff, not just contractor staff, should be more accessible to help physicians and administrators access and interpret these reports.

MIPS review and audits

CMS proposal (p. 28278): Section 1848(q)(13)(A) of MACRA requires CMS to establish a review process that ECs and groups may use to contest the calculation of their MIPS adjustment factor. CMS proposes to adopt the following policies for the MIPS targeted review process:

- ECs would submit their request for a targeted review within 60 days after the close of the data submission period or by July 31.
- CMS would then respond with a decision about whether a targeted review is warranted. If so, the timeline for completing the review would be contingent on the number of review requested and the general nature of the review.
- The agency would not permit a hearing. Rather, CMS proposes clinicians would submit any information they want to be considered in their review at the time of the request. If CMS or its contractors request additional information, ECs would have 10 calendar days to respond and non-responsiveness would result in closure of the review.
- CMS proposes that all targeted review decisions would be final, and there would be no further review or appeal.

CMS also proposes to inform physicians and group practices about their MIPS payment adjustment factor by Dec. 1 of the year prior to the payment year. If technically feasible, CMS would include it in the group's feedback reports. If not, the agency proposes to disseminate this information through another means, such as a portal.

MGMA comment: MGMA has significant concerns about the proposed timeline for the targeted review process. It appears as though CMS is proposing to require groups and physicians to request a targeted review of their MIPS performance long before they have received a feedback report or even MIPS payment adjustment information. MGMA strongly urges the agency to allow targeted review requests on a rolling basis from the data submission deadline until at a minimum 90 days after CMS has provided relevant performance feedback and payment adjustment information to allow practices adequate time to access and interpret their reports, determine the appropriate response, and file an appeal if necessary.

We recommend establishing an appeals process that permits the filing of four different types of appeals: (1) eligibility appeals, (2) MIPS appeals (disputes involving logistics and measure attainment), (3) incentive payment appeals; and (4) audit decision appeals. There would be two levels in the appeals process, an expedited informal review and a final reconsideration.

We urge CMS to develop an automated and streamlined appeals process that would permit ECs and group practices to submit appeal requests by phone, in writing and via a web portal. We also recommend practices with multiple ECs and group practices appealing the same issue be permitted to submit one appeal covering all impacted ECs and group practices in the group.

In addition, we recommend CMS allow ECs and group practices the right, in an expedited fashion, to petition for a change in their hospital-based status when there is a material change in their organizational affiliation (i.e. a physician leaving a hospital-based practice to join an outpatient physician practice). CMS should engage the provider community during development phase of this appeals process for expert guidance in determining appropriate logistics, tools and supporting resources.

Finally, based on the proposals above, we are not confident CMS has incorporated the principles from our recent letter regarding the challenges and pitfalls associated with the current quality reporting program informal review process. We have attached the letter as an appendix and strongly urge the agency to closely review the concerns raised and adopt our recommendations at the outset of MIPS.

MIPS audits

CMS proposal (p. 28279): CMS proposes to selectively audit MIPS ECs on a yearly basis, and should an EC or group be selected for audit, the MIPS EC or group would be required to do the following in accordance with applicable law:

- Comply with data sharing requests, providing all data as requested by us or our designated entity. All data must be shared with CMS or their designated entity within 10 business days or an alternate timeframe that is agreed to by CMS and the MIPS EC or group. Data would be submitted via email, facsimile, or an electronic method via a secure Web site maintained by CMS.
- Provide substantive, primary source documents as requested. These documents may include: Copies of claims, medical records for applicable patients, or other resources used in the data calculations for MIPS measures, objectives and activities. Primary source

documentation also may include verification of records for Medicare and non-Medicare beneficiaries where applicable.

CMS proposes to monitor MIPS ECs and groups on an ongoing basis for data validation, auditing, program integrity issues, as well as instances of non-compliance with MIPS requirements. If a MIPS EC or group is found to have submitted inaccurate data for MIPS, CMS proposes to reopen, revise, and recoup any resulting overpayments in accordance with the rules set forth at § 405.980 (re-opening rules), § 450.982 and § 450.984 (revising rules); and § 405.370 and § 405.373 (recoupment rules). It is important to note that at § 405.980(b)(3) there is an exception whereby CMS has the authority to reopen at any time for fraud or similar fault. If CMS re-opens the initial determination it must be revised, and a notice of the revised determination must be sent out under § 450.982.

MGMA Comments: While we understand conducting audits is an important process for ensuring program integrity, we urge the audit process itself not be administratively burdensome and that the audit process be fully transparent. Most importantly, the audit process should not be strictly punitive, but rather leveraged as an opportunity to educate providers. For example, CMS should compile the audit results and release a comprehensive report on a regular basis outlining what areas providers did well in, as well as those areas where there is room for improvement. Moreover, we recommend that these reports be segmented by medical specialty and practice size.

Public reporting on Physician Compare

Public reporting

CMS proposal (p. 28289): The statute requires CMS to publish the following pieces of information on Physician Compare: clinicians' performance category score and CPSs under MIPS, aggregate MIPS performance information, clinicians participating in Advanced APMs, and Advanced APM performance.

Although CMS proposes to publish all quality, ACI, and CPIA data, the agency would only publish a sub-set of resource use measures, as the agency has found cost measures "can lead to significant misinterpretation and misunderstanding" by the public. For reporting quality and resource use measures, CMS proposes to conduct a reliability analysis to determine a sufficient sample size for public reporting.

MGMA comment: MGMA continues to receive reports of inaccuracies despite practices' multiple attempts to correct the information on their end, as well as complaints related to certain features that are unaddressed by the proposed rule. Inaccuracies are also a reoccurring and frustrating problem for practices that must deal with both the administrative hassles of correcting the misinformation and addressing any undue harm to their reputation. Inaccurate or misleading information would likely confuse beneficiaries and be more harmful to beneficiaries and providers than no information.

To that point, it is not clear that Medicare beneficiaries have any understanding of the MIPS

program or how it affects physician practices. The data CMS currently displays on Physician Compare for other quality reporting program performance is outdated by two years, which is unacceptable and creates confusion. Should CMS move forward with publishing MIPS data, we underscore the importance of putting this information in context for consumers and include an adequate description of the program, including who is eligible, and to use data from the most recent completed reporting year, rather than two years prior. Further, we urge the agency to work closely with measure stewards, providers and consumers to determine how MIPS performance information should be accurately displayed on the website in a manner that can be appropriately understood by beneficiaries.

Review process

CMS proposal (p. 28290): The statute requires CMS to provide clinicians with an opportunity to preview their information before it is publicly reported and submit any corrections. CMS proposes a 30-day preview period and states that the technical details of the process would be communicated in detail directly to affected clinicians and groups outside of rulemaking.

MGMA comment: We recommend CMS expand the preview period from 30 days to a minimum of 90 days. It often takes the agency months to update information on Physician Compare after information has been updated in other CMS systems, yet the agency proposes to give providers only 30 days to verify and take action to change measurement performance data. Additionally, should CMS develop the details of the preview outreach as proposed, we wish to underscore the importance of provider input to this development process and urge CMS to not only engage in a robust discussion and work closely with the provider community throughout the development process, but also follow up with provide robust education and outreach after the process if finalized, to ensure that all practices are well aware of the details and logistics.

APM Scoring Standard for MIPS

Criteria for MIPS APMs

CMS proposal (p. 28234): CMS proposes to create a new class of payment models under MACRA known as MIPS APMs. The agency would define a MIPS APM as a model that meets the following criteria: (1) APM Entities participate in the APM under an agreement with CMS; (2) the APM Entities include one or more MIPS ECs on a participant list; and (3) the APM bases payment incentives on performance (either at the APM Entity or EC level) on cost/utilization and quality measures. MIPS APMs may or may not also be eligible APMs, as these determinations are separate and based on different criteria. As proposed, three models, including Comprehensive End Stage Renal Disease (ESRD) Care (CEC) (non-large dialysis organization (LDO) arrangement), Track 1 MSSP ACOs, and Oncology Care Model (OCM) one-sided risk arrangements qualify as MIPS APMs but not eligible APMs.

MGMA comment: As proposed, the pathway to achieve qualified participant (QP) status in an eligible APM is riddled with hurdles. First, a participant would need to join a model on the “Advanced” APM list, which are virtually non-existent. Second, a participant would be required to meet payment or patient thresholds of engagement in the APM to earn the 5% lump sum bonus. As discussed in subsequent sections, we urge the agency to establish achievable patient

and payment thresholds for QP determinations and expand the eligible APM list. We also support the agency's proposal to simplify reporting for APM participants who would fall short of QP status and would therefore be conscripted into MIPS. Particularly in light of the agency's proposal to make the QP determination after the end of the performance period, it would be essential that participants in eligible APMs would be able to seamlessly participate in MIPS, so in the event they are not QPs in a given performance period, they would not be left scrambling to compile MIPS performance data at the eleventh hour, distracting from the underlying goals of the APM. As described in detail below, we agree with CMS that participants in eligible APMs should report through the APM to minimize administrative burden on the groups that comprise the APM and should be evaluated at the APM Entity level.

However, we are concerned the MIPS APMs pathway would introduce additional layers of complexity into a complicated payment system and may derail the underlying goal of MACRA to incentivize practices to move toward APMs. Under MACRA, the decision for practices was essentially between a fee-for-service payment with a MIPS adjustment or transformation into a risk-bearing model with inherent financial upside and downside, coupled with a lump sum bonus to aid in the transition. However, under the MIPS APMs proposal, CMS has created a potentially attractive middle ground in MIPS APMs, which could ultimately stall progress from MIPS to risk-bearing APMs, as practices would have the added benefits of reduced MIPS burden without the financial risk of an APM. CMS should seek ways to convert MIPS APMs into fully eligible APMs rather than create a new, competing pathway under MACRA.

In summary, while we support CMS' creation of a contingency option for groups and clinicians that would pursue QP status in an eligible APM but fall short of the thresholds in a performance period and would therefore be subject to MIPS, we do not believe MIPS APMs should be an end unto themselves.

APM scoring standard

CMS proposal (p. 28234): CMS proposes to establish a unique MIPS scoring standard for practices and clinicians that participate in APMs to reduce reporting burden by eliminating the need to report under both MIPS and the APM. CMS would assess MIPS performance and make MIPS payments at the APM Entity level, which would be the collection of ECs and groups participating in the APM. The agency would plan to communicate to each APM Entity the MIPS ECs who would be included in the APM Entity in advance of the applicable MIPS data submission deadline for the MIPS performance period. However, if a clinician or group were to leave the APM during the performance period, CMS would require they participate in MIPS through another means. To determine an APM Entity's CPS, CMS proposes to:

- Use quality measure data submitted through the Web Interface to evaluate the quality performance category. For entities that would not submit data through the Web Interface, the APM Entity would not submit data for the MIPS quality performance category until the second performance period.
- Not assess the resource use category because APMs would assess resource use at different levels of care, rather than narrower claims-based and episode-based measures in MIPS.

- Aggregate the CPIA scores of TINs or individual ECs that would participate in the APM Entity to determine an overall APM CPIA score. Each TIN or individual EC would automatically receive half the total points in this category.
- Aggregate the ACI scores of TINs or individual ECs that would participate in the APM Entity to determine an overall APM ACI score.

MGMA comment: CMS should align MIPS and APMs to encourage physician practices to pursue QP status in eligible APMs by reducing the redundancies for eligible APM participants and removing the regulatory burden of switching from MIPS to APMs. CMS should also harmonize the programs to ensure participants who fall short of QP status would not be at an unfair disadvantage in MIPS. As proposed, the agency would not inform ECs and groups of their QP determination until after the MIPS performance period, which may leave them unable to participate successfully and therefore subject to the maximum penalty. Establishing symmetry between the programs would help group practices prepare for risk-bearing arrangements in APMs, as they would become familiar with the EHR and quality components of these models through MIPS.

To align APM performance and MIPS, we suggest the APM Scoring Standard assess APM Entities on quality and CPIA only. As proposed, clinicians participating in APMs would have to proactively submit data for CPIA and ACI prior to knowing if they would meet thresholds to be considered partial QPs or QPs. In later years, it may be possible that an APM Entity would be considered a QP one year and not the following year. Practices and clinicians in these entities would not report CPIA and ACI assuming they would be exempt from MIPS. To avoid confusion on what information would be needed for MIPS and the APM model, CMS should structure the APM Scoring Standard so there would be no additional reporting burden on ECs and groups in APMs.

While we agree CMS should use quality measure data currently submitted for APMs, we do not think this should be limited to APMs reporting through the Web Interface in the first year. CMS should work to eliminate any obstacles with APM quality reporting prior to the first performance period. We agree with CMS that resource use should not be assessed because cost reduction is an underlying goal of all APMs.

As discussed in our comments on the CPIA category, ECs and groups participating in APMs should receive the total points possible for CPIA. In order to achieve the savings that would be required in APM models, APM Entities would need to engage in multiple types of CPIAs, including activities focused on coordination across the care continuum and beneficiary engagement. In recognition of the current level of effort APMs devote to performance, practice improvement and CMS' overall intent to drive payment into APMs, APM participation should be awarded full CPIA points. At a minimum, CMS should allow reporting of CPIAs to occur at the APM Entity level, rather than the aggregate of TINs or individual ECs, to reduce reporting burden.

Finally, ACI should not be scored as part of the APM Scoring Standard but rather use of CEHRT should be incorporated into the APM models. At a minimum, CMS should assess ACI at an

APM Entity level. For example, an APM Entity could meet ACI if they attest to using data produced from CEHRT for population health or information exchange, such as health risk assessment, forecasting, other analytic modeling, feeding registries and exchange with participant network through an HIE or other mechanism.

APM participant identifier

CMS proposal (p. 282236): To identify the ECs and groups participating in an APM, CMS proposes to establish a unique identifier for each APM Entity. CMS also proposes to establish and maintain an APM participant database that would include all of the MIPS ECs who would be part of an APM Entity, including instances when the MIPS ECs would use a billing TIN that is shared with MIPS ECs who would not be participating in the APM Entity. However, the agency would cross-walk its own database against a mandatory APM participant list and would exclude from the MIPS APM's scoring all ECs that would not be listed on the Participant List as of Dec. 31 of the performance period. If a clinician or group leaves the APM during the performance period, CMS would require they participate in MIPS through another means.

MGMA comment: MGMA urges CMS to use the APM participant database, which would provide ongoing insight into which ECs and groups would be actively participating in the APM, rather than the Dec. 31 participant list. At a minimum, CMS should include ECs and group practices in the APM Entity's MIPS score if they were to participate in the APM for more than half of the performance period.

Alternative Payment Models (APMs)

“Advanced” rather than “Eligible” APMs

CMS proposal (p. 28296): MACRA requires an eligible APM meet three criteria: (1) APM participants use CEHRT; (2) the APM pays providers based on quality measures comparable to measures in the quality performance category under MIPS; and (3) the APM Entity either bears risk for losses greater than a specified nominal amount or is part of a Medical Home Model expanded by CMS under their demonstration authority in Section 1115A of the Social Security Act. In the proposed rule, CMS notes the APM bonuses would only be made available to QPs in “Advanced APMs” that are designed to be challenging and involve rigorous care improvement activities.

The proposed Advanced APM list includes only six models: (1) CEC (LDO arrangement), (2) Comprehensive Primary Care Plus (CPC+), (3) MSSP Track 2, (4) MSSP Track 3, (5) Next Generation ACO Model, and (6) the OCM, two-sided risk arrangement.

MGMA comment: The introduction of the term “Advanced APM,” which CMS uses in place of “eligible APM,” as referred to in the MACRA statute, is notable. CMS raises the bar considerably with its definition of an Advanced APM, going much further than required by the statute. In fact, CMS' proposed criteria for what qualifies as an Advanced APM is so stringent that, if finalized, only six APMs would be considered Advanced APMs and be eligible to earn the 5% APM bonus. Finalizing this approach would mean only a small percentage of APM

participants would receive MACRA APM bonus payments. This would represent a serious misinterpretation of the MACRA statute and the Congressional intent behind it. MACRA provides two pathways for clinicians to choose: MIPS or APMs. It does not require participation in “Advanced” APMs, nor does it restrict incentive payments to clinicians in the most highly advanced APMs.

We urge CMS to use a broader and more inclusive approach to defining eligible APMs that would qualify for the MACRA bonus. At a minimum, CMS should include Track 1 MSSP ACOs, the Bundled Payment for Care Improvement (BPCI) models, Comprehensive Care for Joint Replacement (CJR), and accredited Medical Home Models on the final list of Advanced APMs. Not doing so would significantly undermine the efforts of these models, which have been at the forefront of risk-bearing arrangements and promoting health outcomes through better care coordination and quality.

CEHRT criteria for Advanced APMs

CMS proposal (p. 28299): Under MACRA, the first criterion an APM must meet to be considered an Advanced APM is the required use of CEHRT. To determine whether an APM is sufficiently requiring participants to use CEHRT, CMS proposes to require at least 50% of ECs and group practices in an Advanced APM to use CEHRT to document and communicate clinical care with patients and other healthcare providers. Communicating clinical care would mean other ECs and/or the patient could view the clinical care information. CMS would also incorporate the definition of CEHRT that is proposed for MIPS, which would require practices to adopt and use CEHRT that meets the 2015 ONC standards by 2018.

MGMA comment: MGMA supports CMS’ proposed CEHRT requirements for Advanced APM participants, as the proposal provides significant flexibility for existing APMs to leverage current health IT practices and gives new APMs similar flexibility to develop HIT standards that promote the underlying goals of care coordination and cost containment. However, MGMA strongly opposes CMS’ proposed requirement that Advanced APM participants use 2015 CEHRT beginning in 2018. As discussed previously, mandating a switch from 2014 to 2015 CEHRT in a single year for the entire provider community would be exorbitantly costly and disruptive. Based on our members’ experience with the upgrade from 2011 to 2014 CEHRT, MGMA is concerned that many vendors would opt not to meet the new, rigorous standards, leaving their physician trading partners to “rip and replace” their entire EHR system – a process that takes months and costs thousands of dollars. For those physician practices whose EHR systems do certify to the new standards, we are concerned that the cost to upgrade their systems and retrain staff would be significant. MGMA strongly urges CMS to allow practices at least a five-year transition period to move from 2014 to 2015 CEHRT to prevent massive disruptions in not just participation in MIPS and APMs, but also patient care and access to their health information. Further, ONC should be required to issue an annual report, detailing the number of compete ambulatory EHR products that have been recertified to meet the 2015 requirements. Only once a large majority of these products have been recertified should 2015 CEHRT be required for Advanced APM participants.

Quality measurement criteria for Advanced APMs

CMS proposal (p. 28301): Under MACRA, for an APM to be an “Advanced APM,” it must base payment on quality measures comparable to MIPS. CMS proposes to require the APM base payment on at least one outcome measure, if applicable, and one of the following types of measures:

- Any of the quality measures included on the proposed annual list of MIPS quality measures;
- Quality measures that are endorsed by a consensus-based entity, such as the National Quality Forum;
- Quality measures developed under section 1848(s) of the Act;
- Quality measures submitted in response to the MIPS Call for Quality Measures; or
- Any other quality measures that CMS determines to have an evidence-based focus and be reliable and valid.

CMS explains the agency’s goal is “to ensure that APMs have the latitude to base payment on quality measures that meet the goals of the model and assess the quality of care provided to the population of patients that the APM participants are serving.”

MGMA comment: MGMA supports CMS’ proposal to give APMs significant latitude to base performance payments on quality measures that best fit the needs of the care delivery and payment model. In particular, MGMA is pleased CMS recognized the differences among payment models when providing flexibility and autonomy to the model to select measures that would best promote the goals of the model. We agree that the quality measure requirement should not mandate the use of MIPS measures, as models may include new innovate measures that may not be included in MIPS initially. However, as discussed previously, we request CMS clarify how it would determine whether a measure is applicable. CMS should be transparent about how the agency would validate whether an outcome measure is available to a specific payment model.

Financial risk criteria for Advanced APMs (other than Medical Home Models)

CMS proposal (p. 28303): CMS proposes two main components to Advanced APM financial risk: (1) what it means for an APM Entity to bear financial risk for monetary losses under an APM; and (2) what levels of risk CMS proposes to be in excess of a “nominal amount” as required in MACRA. To qualify as “Advanced,” an APM must meet both the financial risk standard and nominal risk standard or be a Medical Home Model expanded under section 1115A of the Social Security Act. The agency proposes that an Advanced APM meet a “generally applicable financial risk standard” such that if an Advanced APM’s actual expenditures for which the APM Entity is responsible exceeds expected expenditures during a specified performance period, CMS would:

- Withhold payment for services to the APM Entity and/or the APM Entity’s ECs;
- Reduce payment rates to the APM Entity and/or the APM Entity’s eligible ECs; or
- Require the APM Entity to owe payment(s) to CMS.

CMS proposes financial risk for monetary loss under an APM must be tied to performance under the model, as opposed to indirect losses related to financial investments made by APM Entities. Although many stakeholders asked CMS to include business risk when defining financial risk for eligible APMs, CMS declined to do so. In the proposed rule, the agency explains, “[t]he amount of financial investment made by APM Entities may vary widely and may also be difficult to quantify, resulting in uncertainty regarding whether an APM Entity had exceeded the nominal amount required by statute.”

MGMA comment: APM participants take on considerable risk as they transition to payment arrangements that reward outcomes rather than volume. Success in a risk-bearing payment model requires practices to take on significant infrastructure investments, furnish uncompensated care, and forego guaranteed performance-based payments if the clinical transformation efforts are not sufficient to reduce waste or improve outcomes. Although business risks may require CMS to think outside the traditional risk calculation box, they are tangible and quantifiable. Further, nothing in the statute requires CMS to exclude these types of risk from inclusion in the financial risk definition. Instead, MACRA provides CMS with broad discretion to define “financial risk for monetary losses under such APM that are in excess of a nominal amount.” As discussed in more detail below, MGMA urges CMS to amend the definition of financial risk to include the loss of guaranteed payments and business risk.

First, CMS should count the loss of guaranteed payments as financial risk, allowing APM participants to treat repayment or withholds of performance-based payments as financial risk. Because investments in HIT or care coordination staff and training do not guarantee shared savings or performance-based payments, APM participants take on significant risk that may not be compensated through performance-based payments. In fact, less than 30% of ACOs have earned shared savings in recent years. Further, this loss is easily quantifiable, as the agency has proven accounting techniques to measure the risk inherent in not meeting the target benchmark to achieve shared savings payments or retain a performance-based payment.

Second, CMS should include business and investment risk in the definition of financial risk. These investments include start-up and operating costs to help fund critical ACO activities designed to improve beneficiary care, enhance care coordination, and reduce unnecessary spending and hospitalizations. For example, APM participants may need to invest in data warehouses to generate patient registries and HIT to support clinical decision-making and communication with patients and other providers. Business risk also involves extending hours, hiring new staff, and furnishing uncompensated services that are the lynchpin of care coordination, such as patient education and consultations with other specialists to ensure seamless care transitions. Although these services are not currently billable and thus not documented, MGMA encourages CMS to work with the appropriate stakeholders, including the AMA CPT Editorial Panel, to develop codes and simple methods for counting these uncompensated services and other business risks, such as attestation.

The National Association of ACOs (NAACOS) recently surveyed its members about the costs of redesigning care delivery to meet the ACO goals of reducing costs and improving quality. The survey found ACOs spend, on average, \$1,622,032 in operating costs to participate in the MSSP. Specifically, respondents factored in the costs related to clinical care, HIT, ACO management,

and other operating expenses. As these results demonstrate, the costs of redesigning care delivery to improve beneficiary health are significant, but not unknown. The \$1.6 million estimate aligns with CMS' previous estimates. In the November 2011 Final ACO Rule, CMS stated:

“In order to participate in the program, we realize that there will be costs borne in building the organizational, financial and legal infrastructure that is required of an ACO as well as performing the tasks required (as discussed throughout the Preamble) of an eligible ACO, such as: Quality reporting, conducting patient surveys, and investment in infrastructure for effective care coordination. [Final ACO Rule, 76 Fed. Reg. 212, November 2, 2011].

“Our cost estimates for purposes of this final rule reflect an average estimate of \$0.58 million for the start-up investment costs and \$1.27 million in ongoing annual operating costs for an ACO participant in the Shared Savings Program” (Final ACO Rule, 76 Fed. Reg. 212, November 2, 2011).

CMS based these estimates in part on those related to the Physician Group Practice (PGP) Demonstration, a precursor to the MSSP that ran from 2005 to 2010. In the November 2011 Final ACO Rule, CMS explained:

“An analysis produced by the Government Accountability Office (GAO) of first year total operating expenditures for participants of the Medicare PGP Demonstration varied greatly from \$436,386 to \$2,922,820 with the average for a physician group at \$1,265,897 (Medicare Physician Payment: Care Coordination Programs Used in Demonstration Show Promise, but Wider Use of Payment Approach May Be Limited. GAO, February 2008) [Final ACO Rule, 76 Fed. Reg. 212, November 2, 2011]. We continue to believe that the structure, maturity, and thus associated costs represented by those participants in the Medicare PGP Demonstration are most likely to represent the majority of anticipated ACOs participating in the Shared Savings Program.” (Final ACO Rule, 76 Fed. Reg. 212, November 2, 2011).

When adjusting for inflation using the Department of Labor Consumer Price Index inflation [calculator](#), the average estimate in the November 2011 Final ACO Rule for ACOs in the MSSP would be \$1,350,867, and adjusting the GAO average estimate for PGP participants in the first year of that program, 2005, would result in \$1,550,844. With repeated estimates providing similar results, it is difficult to see how CMS cannot include them in their calculations of risk. It is also perplexing that CMS acknowledges these investments but refuses to try to find a method to account for them in order to allow these investments to meet requirements for risk. CMS has stated concerns about not being able to properly quantify and verify business risks after accounting for differences in APM operating expenses and market dynamics. MGMA urges CMS to work closely with the appropriate stakeholders to develop a process to account for APM costs and investments to allow these costs to qualify as meeting the standards for more than nominal financial risk.

Nominal risk thresholds required for Advanced APMs (other than Medical Home Models)

CMS proposal (p. 28304): CMS’ proposal for what it means to “bear more than nominal financial risk” is at the heart of what determines whether an APM qualifies as an Advanced APM. To meet the “more than nominal financial risk” criteria required to qualify as an Advanced APM that is not an expanded Medical Home Model, CMS proposes a minimum loss rate (MLR) at or below 4%, marginal risk of at least 30%, and total risk of at least 4% of expected expenditures. CMS proposes an exception where the MLR amount could exceed 4% and still meet the nominal amount standard as long as other portions of the nominal risk standard are met. This would be permissible if: (1) the size of the attributed patient population is small, (2) relative magnitude of expenditures under the APM is small, and (3) if the difference between actual and expected expenditures is not statistically significant.

MGMA comment: First and foremost, CMS should simplify the definition of “more than nominal financial risk.” With multiple components that include total risk, marginal risk and MLR, it is difficult for physicians and practice executives to understand the ramifications of participating in an eligible APM due to the complexity of calculating their financial risk and avoiding losses.

MGMA urges CMS to apply the nominal risk calculation based on physician professional service revenues, rather than expenditures under the APM. PFS services are just 19% of total Medicare Part A and B expenditures, and physicians should not have to take risks for expenses outside of their control

Finally, CMS should reduce the amount of losses defined as “more than nominal financial risk.” CMS’ proposal goes well beyond what Congress intended with their phrasing of “more than nominal financial risk.” On page 28305, CMS states, “In general, we believe that the meaning of “nominal” is, as plain language implies, minimal in magnitude. However, in the context of financial risk arrangements, we do not believe it to be a mere formality... Therefore, in arriving at the proposed values, we sought amounts that would be meaningful for the entity but not excessive.”

The proposed standards are not just slightly more than minimal; they are extremely high. In fact, as part of a discussion related to MIPS in the Notice of Proposed Rulemaking Regulatory Impact Analysis section, CMS discusses thresholds for “significant” risk, stating:

“On average, practitioners’ Medicare billings are only about 22% of total revenue, so even those practitioners adversely affected by MIPS would rarely face losses in excess of 3% of revenues, the HHS standard for determining whether an economic effect is ‘significant.’ (In order to determine whether a rule meets the [Regulatory Flexibility Act] RFA threshold of ‘significant’ impact HHS has for many years used as a standard adverse effects that exceed 3% of either revenues or costs.)” (p. 28365)

If, as CMS states, 3% of a practitioner’s revenue is the agency’s standard for “significant,” why is the agency proposing a loss sharing cap of 4% total cost of care to

meet MACRA requirements for “more than nominal financial risk”? These thresholds are incredibly different and illustrate the proposed 4% loss sharing cap is much too high.

We urge CMS to lower the proposed loss sharing limit for Advanced APMs from 4% to a more reasonable threshold, such as 1% of total Part A and B costs.

Financial and nominal risk requirements for Medical Home Models

CMS proposal (p. 28304): CMS proposes separate financial and nominal risk standards for Medical Home Models to qualify as Advanced APMs. Specifically, CMS proposes a Medical Home Model must meet general financial risk standards, including the three general financial risk standards for Advanced APMs listed in the previous section, plus a fourth option that would only be available for Medical Home Models. This proposed additional option would be based on losing the right to all or some of an otherwise guaranteed payment (e.g., case management fee) contingent on performance against financial or quality metrics. CMS proposes Medical Home Models qualifying as Advanced APMs would need to be at risk to forgo or owe CMS certain percentages of their revenue each year: (1) 2.5% of the APM Entity’s total Part A and B revenue in 2017, (2) 3% in 2018, (3) 4% in 2019, and (4) 5% in 2020 and beyond. As proposed, CPC+ is the only Advanced APM proposed to qualify in 2017 under the Medical Home Model standard.

Beginning in 2018, the financial standards specific to Medical Home Models would only apply to APM Entities with 50 or fewer clinicians. According to the agency, this cap would be appropriate to ensure the focus is on organizations with a limited capacity for bearing the same magnitude of financial risk as larger APM Entities.

MGMA comment: While MGMA supports a different risk standard for Medical Home Models that considers loss of guaranteed payments as financial risk, MGMA is very disappointed CMS essentially ignores the PCMH focus of the definition of eligible APM. In lieu of bearing more than nominal financial risk, MACRA envisioned eligible APMs that are Medical Home Models expanded by CMS as appropriate for the Medicare population under section 1115A of the Social Security Act. However, as proposed, not a single Medical Home Model qualifies as an Advanced APM under this definition. Rather, CPC+, the only Medical Home Model that is a proposed Advanced APM, is a new and geographically-limited CMS Innovation Center (CMMI) model that meets CMS’ alternative risk standard for Medical Home Models. CMS must expand opportunities for group practices participating in accredited Medical Home Models, not just those created by CMMI, but also private sector models that are demonstrating care improvement and cost reduction.

MGMA strongly urges CMS to eliminate the 50-clinician cap on medical homes eligible for the Advanced APM standard. On page 28303, CMS itself states, “We hope to encourage participation in Medical Home Models for all organizations that can derive value from their designs, not just those that are too small to join ACO initiatives and other higher risk APMs.” By arbitrarily capping the size of medical homes eligible for APM bonuses, CMS would achieve the opposite. Further, we learned from CMS officials the cap has less to do with the inherent ability of medical homes to improve care delivery and more with the agency’s desire to drive larger entities into risk-bearing arrangements. However, this logic fails, as Congress in MACRA

supported the expansion of medical homes as the cornerstone for value-based payment reform, and CMS has not created sufficient alternatives to Medical Home Models in the Advanced APM pathway. Thus, by excluding larger organizations from inclusion in the medical home definition of Advanced APM, CMS would not be nudging those groups into greater risk-bearing models but rather forcing them into MIPS.

We believe that Congress intended to exclude medical homes from a nominal risk standard. However, if CMS moves forward with the proposed hybrid approach to including medical homes in the Advanced APM track, MGMA urges the agency to maintain the initial risk standard for medical homes, instead of increasing it to 5%. As discussed previously, CMS' own Regulatory Impact Analysis shows losses in excess of 3% are significant in terms of economic impact on providers and practices. Therefore, because CMS' own data analysis shows that 3% is significant and the MACRA requirements call only for "more than nominal financial risk," CMS should cap the nominal risk standard for medical homes at 2.5%.

Advanced APM qualifying participant and partially qualifying participant determinations

CMS proposal (p. 28304): Under MACRA, QPs in eligible APMs earn a 5% lump sum bonus from 2019-2024, are exempt from MIPS, and receive higher fee schedule updates beginning in 2026. Partial QPs, on the other hand, are not eligible for the 5% bonus or higher fee schedule update, but may choose whether they will be subject to a MIPS payment adjustment, which may be upward or downward. To determine whether an APM participant is a QP or Partial QP, CMS would look at the threshold of payments or patients that flow through the Advanced APM. Under the Medicare only option, the QP payment amount thresholds would be:

- 25% in 2019 and 2020,
- 50% in 2021 and 2022, and
- 75% in 2023 and beyond.

The QP patient thresholds for the Medicare APM option are proposed as:

- 20% in 2019 and 2020,
- 35% in 2021 and 2022, and
- 50% in 2023 and beyond.

Under the Medicare only option, the Partial QP payment amount thresholds would be:

- 20% in 2019 and 2020,
- 40% in 2021 and 2022, and
- 50% in 2023 and beyond.

The QP patient thresholds for the Medicare APM option are proposed as:

- 10% in 2019 and 2020,
- 25% in 2021 and 2022, and
- 35% in 2023 and beyond.

For the purposes of making the QP determination, CMS proposes to attribute a patient to the APM participant only if the patient is eligible for the specific payment model. For instance,

under the CEC Model, one criterion to be an aligned beneficiary requires the beneficiary receive maintenance dialysis services. Under this proposal, CMS would consider beneficiaries that have had at least one maintenance dialysis service billed through the Advanced APM Entity during the performance period as attribution-eligible. On page 28323, CMS explains, “[the agency] would make this exception for the CEC Model to ensure that the denominator of QP determination calculations described in this section only includes payments for services furnished to patients who could potentially be attributed to an Advanced APM Entity under the Advanced APM.”

Finally, CMS also proposes to make the QP and Partial QP determination at the group level. As a result, the QP determination for the group would apply to all the individual ECs who are identified as part of an Advanced APM Entity.

MGMA comment: MGMA supports CMS’ proposal to interpret the QP thresholds expansively and to provide ample opportunities for APM participants to become QPs and Partial QPs by establishing appropriate patient thresholds, particularly at the outset of implementation. We appreciate that CMS considered the inherent design decisions of its payment models, beneficiaries’ underlying care patterns, and the fact that beneficiaries in traditional Medicare retain the freedom of choice to select clinicians. We also urge the agency to finalize its proposal to calculate the thresholds based exclusively on attribution-eligible beneficiaries to reduce the unintended consequences that greater APM participation in a given market could make it impossible for many highly-engaged Advanced APM Entities to reach a 50% or 75% payment threshold. Finally, MGMA supports CMS’ proposal to make the QP and Partial QP threshold determinations at the group level. This is consistent with the fact that APM participants face the risks and rewards of participation as a single unit, as they are collectively responsible for performance metrics that are aggregated at the model level.

Other Payer APM criteria

CMS proposal (p. 28330): Under MACRA, payment arrangements under non-Medicare payers may qualify physician practices for the 5% APM bonus beginning in 2021. Specifically, the agency would define other payer APMs to include payment arrangements under any payer other than traditional Medicare, including Medicare Advantage and Medicaid. CMS also proposes criteria for determining whether Other Payer APMs qualify as eligible APMs.

MGMA comment: MGMA urges CMS to forego finalization of the provisions implementing Other Payer APMs at this time. CMS should gain familiarity with the Medicare APM proposals before expanding these same policies across the entire healthcare system to ensure CMS incorporates any lessons learned in the first few years of implementation as well as addresses any unintended consequences for physician payment that could undermine private sector payment reform initiatives. Given that the stakes are so high and the first payment year under the Other Payer APM is not until 2021, CMS should take the time to get it right.

Physician-Focused Payment Models (PFPMs)

CMS proposal (p. 28345): CMS proposes to define a PFPM as an APM that involves Medicare as a payer, group practices and physicians as participants, and an emphasis on quality and cost of

physician services. CMS proposes a PFPM must meet criteria that align with three underlying goals: (1) payment incentives for high-value care; (2) care delivery improvements including promoting care coordination, protecting patient safety, and encouraging patient engagement; and (3) improving the availability of information to guide decision-making.

MGMA comment: As discussed above, MGMA strongly opposes the overly-narrow and restrictive Advanced APMs criteria proposed by CMS. While MACRA established a requirement that APMs bear more than nominal financial risk, CMS would establish a rigorous risk standard that requires strict repayment of losses – a criterion that excludes the vast majority of legitimate APMs, such as Track 1 MSSP ACOs and the Bundled Payments for Care Improvement models. Setting a soaring hurdle that physician practices must clear to qualify for the incentives that Congress envisioned to promote practice transformation is taking a step backward, rather than forward. We believe CMS should not only amend its proposed definition of eligible APM to conform to congressional intent in MACRA, but also adopt private payer and PFPMs to fill the void.

To maximize provider buy-in and to ensure physicians remain in the driver's seat throughout payment reform, MGMA urges CMS to establish a timely and predictable review process for stakeholder APM proposals, including models for specialists and those recommended by the PTAC, in order to increase MACRA APM opportunities. Physicians are especially concerned by comments from some CMS officials that stakeholder models proposed by PTAC, which was established by Congress, would then have to go through the entire CMS model review process, which suggests it would be years before any physician-focused APMs are available. MGMA urges CMS to give deference to PTAC-recommended payment models, particularly those that fill a gap on the Advanced APM list or complement existing Advanced APMs. We believe this is the best way to encourage physicians to develop and participate in innovative risk-based payment models that give clinicians the flexibility to deliver a more unique set of services than the restrictive requirements that payment systems currently allow, while keeping administrative costs to a minimum.

Conclusion

We appreciate the opportunity to share our concerns about the proposed framework for MIPS and APMs and to offer our recommendations to improve and simplify these programs to support groups practices as they transform their practices and receive payment based on outcomes rather than volume. Should you have any questions, please contact Anders Gilberg, Senior Vice President, Government Affairs at agilberg@mgma.org or 202-293-3450.

Sincerely,

/s/

Halee Fischer-Wright, MD, MMM, FAAP, CMPE

President and CEO