October 1, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program; CY 2021 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Verma:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the proposed rule entitled, "CY 2021 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies," file code CMS–1734-P.

MGMA is the premier association for professionals who lead medical practices. Since 1926, through data, people, insights, and advocacy, MGMA empowers medical group practices to innovate and create meaningful change in healthcare. With a membership of more than 58,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 organizations of all sizes, types, structures, and specialties that deliver almost half of the healthcare in the United States.

Key Recommendations

MGMA appreciates the Centers for Medicare & Medicaid Services' (CMS') leadership in improving Medicare and respectfully offers the following comments on the proposed 2021 Physician Fee Schedule (PFS). In summary, we encourage the agency to:

- **Continue to reimburse audio-only remote visits at a rate that adequately covers the cost of care**. Audio-only visits are a lifeline for certain beneficiaries who lack the ability to attend in-person visits, lack broadband access, and/or do not possess adequate technology to participate in video visits. CMS should reimburse providers for these services following the end of the COVID-19 public health emergency.
- **Move forward with implementing improvements to E/M office visits on Jan. 1, 2021 but take action to prevent physician payment cuts due to budget neutrality adjustments.** CMS should exercise its administrative authority to avert or, at a minimum, mitigate these payment cuts.
- **Align CPT code 99XXX guidance with the CPT Editorial Panel's guidance and provide more clarity on intended utilization of HCPCS code GPC1X.** MGMA agrees with CMS that reimbursement for E/M visits does not always adequately describe or reflect the resources associated with primary care and certain types of specialty visits.

- **Implement an *automatic* hardship exception for participants in the Merit-based Incentive Payment System (MIPS) for the 2020 and 2021 performance years, similar to the policy implemented for the 2019 performance year.** As we expect the coronavirus will continue to impact the healthcare system into 2021, continued flexibility is needed to support medical groups and avoid creating additional burden, such as a requirement to submit a hardship application.
- **Delay proposed changes to Medicare Shared Savings Program (MSSP) ACO quality reporting for at least one year.** While MGMA appreciates CMS' intent is to reduce reporting burden, we have concerns around certain aspects of quality changes and believe more time is needed to gather stakeholder feedback. We also urge CMS to maintain pay-for-performance years for new ACOs and for existing ACOs in certain cases, such as newly introduced measures.
- **Maintain the MIPS performance threshold at 45 points, as well as maintain the weight of the cost category at 15% and quality category at 45% of the final MIPS score for 2021.** In light of the COVID-19 pandemic, we urge CMS to avoid adding administrative burden and instead ask the agency to reduce it to allow group practices to focus on caring for patients during these uncertain times.
- **Avoid moving from the MIPS APM scoring standard to the APM Performance Pathway (APP) in 2021.** The proposed approach does not take into consideration the diversity of MIPS APMs and instead would subject them all to the same quality measure set.
- **Finalize the proposal to create a process for Advanced APMs to request a targeted review for potential errors in qualifying participant (QP) calculations or Participant Lists.** Following the inaugural performance year of the Quality Payment Program (QPP), MGMA heard from group practices that encountered errors in these methodologies. We appreciate CMS' recognition that inadvertent errors may occur, necessitating a formal review process.

Physician Fee Schedule

Telehealth

Adding services to the Medicare telehealth list

CMS proposal (85 Fed. Reg. 50095): CMS proposes to add nine services to the Medicare telehealth list on a Category 1 basis and 13 services to the list on a newly created Category 3 basis. CMS also solicits comments on whether additional services added to the telehealth list during the COVID-19 public health emergency should be made permanent.

MGMA comment: MGMA supports the proposal to add nine codes to the list of approved telehealth services on a permanent basis. Before the COVID-19 pandemic, telehealth had very low adoption rates, with only 13,000 beneficiaries in Medicare fee-for-service receiving telehealth services in a week.[1] Since telehealth expansion waivers went into effect following Secretary Azar's COVID-19 public health emergency declaration, access to remote care has increased significantly; for example, over nine million Medicare beneficiaries received a telehealth service between March 17, 2020, and June 13, 2020.[2] These data highlight how the flexibilities implemented by this Administration significantly transformed telehealth coverage and facilitated care delivery during the COVID-19

[1] Seema Verma, "Early Impact of CMS Expansion of Medicare Telehealth During COVID-19," Health Affairs, July 15, 2020.
[2] *Id.*

public health emergency. The addition of over 100 codes to the telehealth list has been a lifeline for certain practices, who can offer expanded services to patients unable to go into the office for an in-person visit. MGMA and our member group practices appreciate the steps CMS has taken to expand remote access to care during the public health emergency.

In addition to supporting the permanent addition of new telehealth codes, MGMA supports the proposal to include an additional 13 codes on the Medicare telehealth list on a temporary basis; however, we recommend these 13 services be added permanently. We heard from our member group practices that adjusting workflows to operationalize the use of new telehealth codes requires additional resources, such as clinician and staff training and education. Removing telehealth services from the covered code list will be frustrating and disruptive to both practices and patients alike, as patients will become accustomed to receiving these services virtually. Instead of removing services after a predetermined or prescriptive date, CMS should permanently add them and let clinicians decide when it is appropriate to furnish such services virtually. Alternatively, CMS could permanently add the 13 codes but monitor their utilization to assess impact on program/patient cost and clinical efficacy. Depending on the outcome of its evaluation, CMS could propose through formal rulemaking to remove services from the telehealth covered code list that do not meet pre-established standards, such as improving or maintaining quality outcomes, when furnished virtually.

CMS seeks comment on whether certain additional services that were added to the telehealth list during the public health emergency should be added to the list temporarily or permanently post-public health emergency. As discussed previously, the addition of codes to the list on a temporary basis could create uncertainty and administrative burden for medical groups, along with potential stress on their patients.

Audio-only visits

CMS proposal (85 Fed. Reg. 50113): In the March 30 COVID-19 interim final rule with comment (IFC), CMS established separate payment for audio-only E/M services (CPT codes 99441-99443) by removing their previous status as "non-covered." In the 2021 proposed PFS, CMS is not proposing to continue to reimburse for these services upon the conclusion of the COVID-19 public health emergency. CMS states that outside of the public health emergency, it does not have the ability to waive the requirement that telehealth services be furnished using an interactive telecommunications system that includes two-way, audio/video communication technology. Instead of proposing to continue coverage of these codes, CMS seeks feedback on whether it should develop coding and payment for a service similar to virtual check-ins, but for a higher value and longer time.

MGMA comment: Throughout the COVID-19 public health emergency, MGMA has received feedback from group practices on the incredible value of audio-only codes. In an August 2020 poll conducted by MGMA, 82% of respondents reported that they have billed an audio-only service during the public health emergency.[3] One MGMA member practice reported that 46% of Medicare patient visits were performed using audio-only services between April and August 2020. MGMA members report that in some cases, these services are the only means of treating certain patients virtually. The following patient populations could benefit from the permanent inclusion of audio-only services:

- **Patients with poor broadband access.** For patients who have limited broadband access due to geographic location, audio-only visits may be the only means of accessing care if they cannot go into the office. A 2019 Federal Communications Commission (FCC) report

[3] MGMA poll, Physician Fee Schedule Q&A, Aug. 26, 2020

estimates that over 21 million individuals do not have access to broadband.[4] Further, researchers have estimated that 41% of Medicare patients lack access to a desktop or laptop computer with a high-speed internet connection at home.[5]

- **Patients who lack access to the requisite equipment to accommodate video functionality.** Audio-only visits provide access to care for patients who do not have adequate equipment to participate in audio *and* visual telehealth visits.
- **Patients with limited digital literacy or access, such as those with low income, limited English proficiency, or other disparities.** Studies have shown that low-income individuals have lower rates of smartphone ownership (71%), home broadband access (59%), Internet use (82%), and basic digital literacy (53%).[6] Every group practice cares for patients with vulnerabilities that may reduce access to video technology or limit digital literacy. Expanding access to care through reimbursement for audio-only services is one way to mitigate widening gaps in health disparities.

MGMA believes that CMS has the authority to modify the regulatory definition of "interactive telecommunications system" at 42 CFR 410.78(a) to allow reimbursement for audio-only interactions. The provision authorizing Medicare payment for telehealth services, section 1834(m) of the Social Security Act, describes the modality required as a "telecommunications system;" the statutory text does not contain language requiring both audio and visual capabilities. Instead, these elements are codified in the regulatory definition at 42 CFR 410.78(a)(3). That provision, in pertinent part, defines modality as: a "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner."

Recognizing that audio-only services may not offer all the benefits of in-person care, and may not even match the benefits of virtual services with video functionality in all cases, audio-only services still provide a lifeline to patients who are unable to attend visits in person or are unable to participate in video visits. Clinicians should be permitted to decide when video modalities are required for a specific clinical encounter.

Given the video requirement is codified in regulation rather than statute, MGMA submits that CMS has the authority to amend this definition through rulemaking and allow for the continued payment of audio-only telehealth services even absent waiver authority. As such, MGMA requests that CMS issue an interim final rule with comment to amend the definition of "telecommunications system" at 42 CFR 410.78 and allow reimbursement for audio-only services. If CMS disagrees and believes it does not have such authority, MGMA urges the agency to develop coding and payment for a service similar to virtual check-ins but with a higher value and a longer unit of time.

Without congressional action amending the originating and geographic restrictions under 1834(m) of the Social Security Act, the vast majority of Medicare beneficiaries in non-rural areas will not have access to telehealth services following the conclusion of the COVID-19 public health emergency. Therefore, we strongly believe that, so long as the geographic and originating site restrictions are still in place under 1834(m), CMS should develop a new code to cover audio-only visits to allow beneficiaries living in non-rural areas to access this service. MGMA recommends CMS consider the

[4] FCC, "2019 Broadband Deployment Report," May 19, 2019.
[5] Eric T. Roberts, PhD1; Ateev Mehrotra, MD, MPH, "Access Among Medicare Beneficiaries and Implications for Telemedicine," JAMA Internal Medicine, Aug. 3, 2020.
[6] Sarah Nouri, MD, MPH; Elaine C. Khoong, MD, MS; Courtney R. Lyles, PhD; Leah Karliner, MD, MAS, "Addressing Equity in Telemedicine for Chronic Disease Management During the Covid-19 Pandemic," New England Journal of Medicine, May 4, 2020 (internal citations omitted).

following when developing coding and payment for new audio-only services:

- The code should be available to patients regardless of patient location;
- The code should be available to both new and established patients;
- Reimbursement for this code must be high enough to adequately cover the cost of delivering care. MGMA has heard from member practices that audio-only visits still require a similar amount of effort on the part of the practice than in-person visits do. Practices still must schedule visits, facilitate the calls, virtually check-in patients, document the visits, and follow-up with patients. There are also technical issues during the visit that could require troubleshooting on the part of the practice, which takes up staff time. CMS should consider reimbursing these visits at levels similar to in-person ones and make sure to account for varying levels of visit complexity and time when valuing the code(s); and
- This code should be permanent and remain in effect following the public health emergency.

Technical amendment to remove references to specific technology

CMS proposal (85 Fed. Reg. 50112): CMS proposes to permanently retain revisions to 42 CFR 410.78(a)(3) that remove the provision specifying that ''[t]elephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.''

MGMA comment: MGMA supports this proposal. Throughout the COVID-19 public health emergency, MGMA member group practices have been able to successfully facilitate telehealth appointments via smartphones. A recent study published in JAMA found that 41% of Medicare beneficiaries lacked access to a desktop or laptop computer with a high-speed internet connection at home.[7] Telephones provide an opportunity to participate in a telehealth visit if a computer is unavailable. This policy will allow for increased access to care in the future and should remain in effect past the expiration of the public health emergency. Lastly, finalizing this proposal could pave the way for coverage of audio-only telehealth visits via telephones.

Communication Technology-Based Services (CTBS)

Services furnished by non-physician practitioners (NPPs)

CMS proposal (85 Fed. Reg. 50112): CMS proposes to allow licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists to bill additional CTBS services. Starting in 2021, these clinicians would be permitted to bill for online assessment and management for established patients using G2061-G2063. Additionally, CMS proposes to create two additional G-codes for practitioners who cannot independently bill for E/M services that would align with G2010 and G2012.

MGMA comment: MGMA supports these proposals. Allowing these NPPs to bill G2061-G2063 will support practices in advancing coordinated care efforts. Further, it could help mitigate problems associated with physician workforce shortages, which is slated for a shortage of between 54,100 and 139,000 physicians by 2033.[8]

Impediments that result in reluctance to bill for CTBS

CMS proposal (85 Fed. Reg. 50112): CMS seeks feedback on any impediments that contribute to healthcare provider burden and that may result in practitioners being reluctant to bill for CTBS.

[7] Roberts, *supra*, note 5.
[8] AAMC, "The Complexities of Physician Supply and Demand: Projections from 2018-2033," June 2020.

MGMA comment: MGMA strongly supports CMS' efforts to cover and expand access to these services. However, the reality is that the requirement to collect patient copays and low reimbursement rates make these codes unrealistic for many physician practices. An MGMA poll conducted in 2019 revealed that on average, it costs a practice $7.62 to generate and send a patient bill.[9] The national average payment rate in the non-facility setting is $12.27 for G2010 and $14.80 for G2012 in 2020, meaning the cost to generate and transmit a patient bill offsets over half the reimbursement rate for these services. MGMA understands that CMS does not have the authority to waive the requirement to collect patient copays when they are required; therefore, we urge CMS to consider valuing CTBS at a higher rate such that practices can successfully utilize these codes.

Care Management Services

Remote physiological monitoring (RPM) services

CMS proposal (85 Fed. Reg. 50117): CMS proposes to make permanent two policies permitted during the COVID-19 public health emergency: (1) to permit auxiliary staff to furnish CPT codes 99453-99454 under a physician's supervision and (2) to allow consent to be obtained at the time of an RPM service. CMS also solicits feedback on whether to permit payment for RPM services with shorter monitoring periods in recognition that 16 or more days over a 30-day period may not be necessary.

MGMA comment: MGMA supports both permitting auxiliary staff to furnish RPM services under a physician's supervision and allowing groups to obtain contemporaneous Medicare beneficiary consent for these services.

We encourage the agency to provide reimbursement in cases where patient monitoring is less than 16 days. There are situations wherein longer monitoring is not necessary. For example, a member group practice reported that their endocrinologists monitor blood sugar and blood pressure on a weekly basis for certain patients with chronic disease, but that these monitoring efforts do not always meet the current duration requirements for reimbursement. Remote and virtual services offer opportunities to increase access to high-value care when furnished to established patients, particularly those with chronic conditions or complex comorbidities and those facing barriers to care due to geography or socioeconomic factors.

E/M Services

CMS proposal (85 Fed. Reg. 50137): CMS calculates the annual conversion factor based on, inter alia, estimates regarding service utilization to ensure that budget neutrality is maintained. The 2021 conversion factor is estimated to be $32.2605, which is nearly a 11% reduction from the 2020 conversion factor. There are several considerations that influence the conversion factor, and for 2021, this includes changes to E/M services.

MGMA comment: MGMA strongly supports CMS' adoption of the AMA CPT Editorial Panel coding guidelines and the AMA/Specialty Society Relative Value Scale Update Committee (RUC)-recommended values for E/M services starting Jan. 1, 2021. However, MGMA has significant concerns about the impact of budget neutrality cuts on those physicians and clinicians who do not typically report E/M codes, including radiologists, pathologists, and physical therapists, as these clinicians face estimated payment cuts of 9% to 11% solely due to budget neutrality, as estimated in Table 90 of the proposed rule. We joined 170 associations and societies in a July 2020 letter urging the Department of Health & Human Services (HHS) and CMS to not apply budget neutrality requirements for the E/M changes. We wish to reiterate the concerns and recommendations

[9] MGMA, Advocacy Poll: Billing Costs and Time Frame, July 2019.

expressed in that letter in our comment letter, including urging HHS and CMS to use any and all authority available to not apply PFS budget neutrality in 2021.

CPT code 99XXX

CMS proposal (85 Fed. Reg. 50138): CMS proposes that CPT code 99XXX could be reported when clinicians use time to select E/M visit level and the maximum time for the level 5 visit is exceeded by at least 15 minutes on the date of service.

MGMA comment: MGMA recommends that CMS align its policy on CPT code 99XXX with the AMA CPT Editorial Panel's guidance that time related to prolonged services begins at the starting point of the code range, as opposed to when the time exceeds the top of the time range. As proposed, practitioners would have to see a level 99215 patient for 69 minutes or a level 99205 patient for 89 minutes to bill CPT code 99XXX. This deviation from the AMA CPT guidance will cause confusion and place more burden on physician practices to account for different time ranges. MGMA recommends that CMS work to align the time ranges for utilizing CPT code 99XXX with AMA CPT Editorial Panel guidance.

HCPCS code GPC1X

CMS proposal (85 Fed. Reg. 50138): In the 2020 final PFS, CMS finalized its proposal to create a new add-on code (HCPCS GPC1X), which describes the ''visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex condition.'' In the CY 2021 proposed PFS, CMS seeks feedback on what aspects of the definition of GPC1X are unclear and how it could address those concerns.

MGMA comment: MGMA agrees with CMS that reimbursement for E/M visits does not always adequately reflect the resources associated with primary care and certain types of specialty visits. We believe it necessary for CMS to provide more information and overall clarity regarding utilization assumptions of GPC1X due to the potential meaningful impact it can have on the overall budget neutrality adjustment and in turn, the conversion factor.

In response to the CY 2020 proposed PFS, MGMA commented with a series of questions regarding HCPCS add-on code GPC1X that needed further clarification. Following the publication of both the CY 2020 final PFS and the CY 2021 proposed PFS, MGMA still requests the follow questions be answered:

- How should a practitioner document HCPCS add-on code GPC1X in the medical record?
- When reporting GPC1X, how would a practitioner differentiate between using the add-on code or selecting a higher visit level?
- Is the "visit complexity" language in the HCPCS add-on code GPC1X descriptor referring to a complex visit or the complexity of the "single, serious or complex" chronic condition? Furthermore, how does CMS plan on defining "serious?"

In order for medical groups to successfully utilize and receive payment for HCPCS add-on code GPC1X, CMS must provide more information regarding documentation and how to use this code in general. Additionally, Medicare Administrative Contractors will not be able to process this new code without sufficient guidance from CMS. Clarifying the points outlined above will assist practitioners in being able to bill HCPCS add-on code GPC1X.

Lastly, MGMA requests clarification on CMS' intended descriptor for HCPCS GPC1X. Table 8 in

the proposed rule includes a different descriptor than what was finalized in the 2020 rule. The descriptor in Table 8 of the proposed rule refers to complexity inherent to E/M services with primary medical care services that serve as the continuing focal point for all needed healthcare services. This differs from the 2020 final rule descriptor which states GPC1X should be used for visit complexity inherent to E/M services associated with medical care services that serve as the continuing focal point for all needed healthcare services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. The two conflicting descriptors will cause further confusion if not addressed in the final rule.

Medicaid Promoting Interoperability (PI) Category

Medicaid PI: Alignment with MIPS

CMS proposal (85 Fed. Reg. 50227): "We anticipate that this proposal would reduce burden for Medicaid EPs by aligning the requirements for multiple reporting programs, and that the system changes required for EPs to implement this change would not be significant, particularly in light of our belief that many EPs would report eCQMs to meet the quality performance category of MIPS and therefore should be prepared to report on the available eCQMs for 2021."

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

Medicaid PI: Required measures

CMS proposal (85 Fed. Reg. 50227): "For 2021, we propose to again require (as we did for 2020) that Medicaid EPs report on any six eCQMs that are relevant to their scope of practice, regardless of whether they report via attestation or electronically. This policy of allowing Medicaid EPs to report on any six measures relevant to their scope of practice would generally align with the MIPS data submission requirement for eligible clinicians using the eCQM collection type for the quality performance category, which is established at § 414.1335(a)(1)."

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

Medicaid PI: Reporting period

CMS proposal (85 Fed. Reg. 50228): "Finally, we note that the eCQM reporting period in 2021 for EPs in the Medicaid PI Program is a minimum of any continuous 90-day period within CY 2021, provided that the end date for this period falls before October 31, 2021, or falls before a state-specific alternative date prior to October 31, 2021 that is specified in the SMHP, as described in § 495.332(f)(4). This 2021 eCQM reporting period will help ensure that states can issue all Medicaid PI Program payments on or before December 31, 2021. (See 83 FR 59452, 59704 through 59706)."

MGMA comment: With the Medicaid PI program slated to end in 2021, we understand why the

agency would seek to shorten the reporting period to any 90 consecutive days between Jan. 1, 2021 and Oct. 31, 2021. We support this shortened reporting period and believe this approach will continue to provide CMS with more than sufficient data while significantly reducing the administrative burden associated with reporting the data.

Medicaid PI: Final program year

CMS proposal (85 Fed. Reg. 50266): "We are not proposing any changes to these measures, as the final year of the Medicaid PI Program is 2021."

MGMA comment: As this is the last year of the Medicaid PI program, we support the CMS proposal to continue 2020 policies through the 2021 performance year. We also support agency efforts that align the Medicaid PI program with the MIPS PI program including:

- Aligning the eCQMs available for Medicaid eligible clinicians in 2021 with those available for MIPS eligible clinicians for the CY 2021 performance period;
- Requiring that Medicaid eligible clinicians report on any six eCQMs that are relevant to their scope of practice, regardless of whether they report via attestation or electronically; and
- Reporting on at least one outcome measure (or, if an outcome measure is not available or relevant, one other high priority measure).

The continuation of these policies reflects an effort to reduce the reporting burden associated with participation in these programs and providing program participants with necessary reporting flexibility and program stability. Program and reporting stability are especially important during the COVID-19 public health emergency when providers should focus on caring for their patients.

MSSP

CMS proposal (85 Fed. Reg. 50227): CMS proposes to revise the current quality performance structure for ACOs participating in the MSSP starting in the 2021 performance year by:

- Narrowing the quality measure set an ACO must report from 23 to six. CMS would add two administrative claims measures calculated on ACOs' behalf by CMS using Medicare claims data;
- Increasing the minimum quality performance threshold and making changes to the way quality scores contribute to shared savings and loss calculations. ACOs would be required to receive a quality performance score equivalent to or above the 40th percentile;
- Eliminating the Web Interface reporting mechanism and replacing it with the new APP; and
- Removing the pay-for-reporting year.

MGMA comment: As an overarching matter, we appreciate that CMS considered how to reduce quality reporting burden on ACOs and provide flexibility in how quality measures are submitted. However, we believe there are operational details and measurement concerns that must be addressed before finalizing such substantial changes to ACO quality measurement, as outlined in greater detail below. Furthermore, the proposed timeline is far too short; not only is the nation still in the midst of a pandemic, the expected delayed release of the final rule until December 2020 further reduces the amount of time ACOs will have to respond to any changes. The proposed quality measurement revisions will require ACOs to make changes to operational workflows, secure new technology capabilities, and familiarize themselves with reconfigured measure sets.

We ask that CMS not finalize certain proposals for the 2021 performance year and instead take more time to gather input from the stakeholder community on how to make changes to ACO quality measurement in the future. As a general matter, CMS should also endeavor to permit sufficient time between finalizing a rule and implementation start date to provide education, outreach, and support on any significant revisions.

MSSP: APP measure set

CMS proposal (85 Fed. Reg. 50230): CMS proposes to require the new APP measure set for all MSSP ACO participants; the APP would evaluate ACOs on three clinical measures, one measure based on CAHPS scores, and two new administrative claims measures. The agency would also apply the APP for purposes of QPP reporting requirements starting with the 2021 performance period.

MGMA comment: MGMA does not support moving MSSP ACOs to the APP measure set beginning in 2021. In general, we support reducing reporting burden but have concerns about reducing the number of clinical quality measures to just three. We believe further consideration must be afforded as to whether the proposed balance of measures is appropriate (e.g., proportion of clinical, patient experience, and administrative claims measures).

ACOs should be evaluated on quality measures that reflect core competencies of the ACO, such as care coordination activities and preventative health. The proposed measure set reduces clinical measures to three. While we support efforts to reduce reporting burden, we respectfully request that the agency take more time to carefully consider measure selection, determine the appropriate clinical measure set, and proportion of measure types. We generally agree the three clinical measures proposed by CMS reflect important clinical priority areas that ACOs should focus on but are concerned that reducing these measures to three allows little room for random variation in one measure.

In addition to changes to the clinical measure set, proposed changes to quality reporting would streamline CAHPS scores into one measure. MGMA agrees that patient experience data is critically important, but CMS does not clearly detail how it would create one composite CAHPS measure score. Further, CAHPS measures have narrow bands, which means that minor differences in results can cause significant variation in scores. We generally have concerns around using administrative claims measures and encourage the agency to engage in further testing for risk adjustment, which should include social risk factors. CMS has not produced comprehensive measure specifications, which raises concerns about the ability of ACOs to understand how they will be measured and how to implement measures in practice. This potential for unpredictability, coupled with variance due to risk adjustment changes in the two administrative measures, creates significant uncertainty regarding quality scores since the CAHPS measure and two administrative claims measures would account for half of an ACO's quality score.

For these reasons, we recommend CMS postpone any major transition and utilize this time to consult with the ACO community to determine a balanced measure set.

MSSP: Removing Web Interface

CMS proposal (85 Fed. Reg. 50230): CMS proposes to remove the Web Interface reporting mechanism for ACOs, MIPS APMs, group practices, and virtual groups starting with the 2021 performance year.

MGMA comment: We oppose the proposal to sunset the Web Interface reporting mechanism in 2021 and instead encourage CMS to delay this policy until the 2022 performance year at the earliest. While we appreciate that this proposal is intended to provide ACOs more flexibility by adding new

reporting options rather than limiting ACO reporting to the Web Interface, switching to an alternative reporting mechanism takes time and consideration.

Importantly, retiring the Web Interface will modify how ACOs are evaluated on quality measures. When ACOs report via the Web Interface, they provide CMS with data about Medicare beneficiaries that are specific to each Web Interface measure. In contrast, the remaining MIPS reporting options available to ACOs, registry (CQM) and EHR (eCQM), evaluate data on *all* patients, regardless of payer, that meet measure denominator criteria. Therefore, eliminating the Web Interface option would result in a significant change in how ACOs are evaluated on quality metrics, since the remaining options consider all patients, rather than a predefined set of patients. More time is needed to evaluate whether this is appropriate and, if so, for ACOs to understand the implications of this change.

Additionally, this proposal raises operational questions and concerns. ACOs moving to CQM or eCQM may encounter technical difficulties and data-sharing limitations that arise from lack of interoperability. ACOs often consist of several group practice TINs that all work together to achieve the goals of the ACO and the program. This entails coordination across multiple practice sites, which may utilize several different EHRs, and in some cases, upwards of a dozen different systems. For an ACO that uses multiple systems, the shift away from Web Interface to CQM or eCQM may require additional capabilities to enable reporting, such as retention of a separate third-party vendor to aggregate patient data across these systems or added functionalities to existing products. This involves not only added expenses but also learning and implementing new workflows. ACOs and their participant groups need time to make these changes and secure appropriate vendors and/or added technological capabilities within their current systems. They should be afforded an appropriate period of time to consider all available options, rather than being forced to rush into a contract that may not be the best fit but offers the quickest solution.

MSSP: Quality performance score

CMS proposal (85 Fed. Reg. 50234): CMS proposes to change the quality performance standard for MSSP ACOs from the 30th percentile on one measure to a requirement that ACOs achieve a quality score equivalent to the 40th percentile or above across all quality scores.

MGMA comment: While the proposal to increase quality performance scores may seem reasonable given ACOs have historically achieved high quality scores, MGMA recommends that CMS delay finalizing this proposal until 2022 at the earliest. We do not believe that the 2021 performance year is an appropriate time to increase quality performance requirements given the uncertainty created by COVID-19. CMS estimates that 95% of ACOs would exceed the proposed threshold, but this figure is based on prior year data when the country was not in the midst of an unprecedented pandemic and does not consider proposed changes to the quality measure set. ACOs do not know whether the pandemic will impact their quality performance scores, which introduces uncertainty at a time when they need more stability. We strongly encourage CMS to delay this proposal.

If CMS moves forward with finalizing this proposal for a future year, we request that the final rule clarify how CMS intends to apply the threshold quality score requirement. In the proposed rule, the agency does not clearly state whether ACOs must achieve a 40% quality score based on the *aggregate* of quality measures or achieve a 40% score on *each individual* measure. While CMS has inferred informally in proposed rule education and outreach that it intends to apply this threshold at the aggregate level, this must be codified in regulatory text. We urge the agency to clarify this in the final rule and to finalize a policy that sets this threshold for the *aggregate* of quality measure scores, rather than failing an ACO based on one measure score below the threshold.

MSSP: Removing pay-for-reporting year

CMS proposal (85 Fed. Reg. 50252): CMS proposes to remove the pay-for-reporting year, which currently applies to ACOs beginning an initial MSSP contract, as well as when individual measures are newly introduced or undergo significant changes, such as guideline changes.

MGMA comment: We oppose this proposal and urge CMS to retain the pay-for-reporting year policy. Providing a pay-for-reporting year in certain instances permits an ACO to evaluate its workflows, data capture processes, and other operational strategies to assess where changes are needed. Further, providing a pay-for-reporting year for a newly introduced measure or measure undergoing significant changes mitigates the potential for unintended consequences or flaws in measure specifications before holding an ACO accountable for performance.

MSSP: Remaining 2020 proposals

CMS proposal (85 Fed. Reg. 50252): CMS proposes changes to the quality reporting requirements for the 2020 performance year to mitigate potential reductions in 2020 performance by using the higher of 2019 or 2020 scores.

MGMA comment: MGMA supports the proposal to waive the requirement that ACOs conduct CAHPS surveys in 2020. We also encourage CMS to finalize the policy outlined at 85 Fed. Reg. 50254 to score ACOs on the higher of 2019 or 2020 quality scores.

QPP: MIPS and APMs

At the outset of our comments on QPP proposals, we wish to address COVID-19's impact on group practices' ability to participate in the QPP and offer recommendations for CMS for the 2020 and 2021 performance years.

MIPS: Recommendations to aid COVID-19 response

CMS proposal (85 Fed. Reg. 50276): CMS makes certain modifications to 2020 QPP requirements in response to the COVID-19 pandemic.

MGMA comment: MGMA appreciates the policy CMS implemented for the 2019 performance period that granted an *automatic* exception to MIPS reporters that could not submit 2019 data and established an extreme and uncontrollable circumstances hardship application process for others. We urge CMS to extend similar protections for the 2020 and 2021 performance periods. While the traditional hardship application process is available, we believe the hardship should be applied automatically as it was for 2019.

In instances where a clinician or group submits MIPS performance data to CMS, CMS should apply the *higher* of the MIPS performance threshold score for the year *or* the actual score a clinician/group would receive based on submitted data. This approach would encourage reporting for those capable of participating in the program and submitting data, while protecting group practices from any gaps in data or unexpected events that may prevent either performance during the performance year or impede the ability to submit data during the subsequent reporting period. CMS should provide practices with assurances that they will not receive a payment penalty for circumstances beyond their control. Providers across the country continue to face new challenges due to the COVID-19 pandemic, which we anticipate will continue throughout the next several months and potentially another full year if COVID-19 cases continue to increase.

While not all areas of the country or all group practices see large numbers of COVID-19 patients, every group practice, hospital, and clinician is operating in a COVID-19 environment, necessitating increased attention toward new workflows; infection control; monitoring and implementing changing

federal, state, local, or clinical and safety guidelines; and tracking and responding to new hot spots. This environment is unpredictable, requiring groups to adapt swiftly to accommodate changes, sometimes overnight.

Even as the country and healthcare system move from response to rebuilding to recovery, there is a continued need for regulatory flexibility to allow group practices to focus on what matters most: patient care**.** For these reasons, we strongly recommend that CMS institute an automatic MIPS hardship exception process for 2020 and 2021 that automatically holds clinicians and group practices harmless for unavoidable gaps in quality reporting data. It is confusing for groups to keep track of changing policies year-over-year and applying 2019 hardship flexibilities for 2020 and 2021 will create consistency. We encourage CMS to finalize this policy sooner rather than later, as it is critical that group practices have assurances of regulatory flexibilities in advance, where possible, to mitigate stress and reduce uncertainty.

Advanced APMs: Recommendations to aid COVID-19 response

CMS proposal (85 Fed. Reg. 50276): CMS makes certain modifications to 2020 QPP requirements in response to the COVID-19 pandemic.

MGMA comment: For Advanced APM participants, we urge CMS to offer participants the option to mitigate downside financial risk in exchange for reduced upside risk for all performance years impacted by the COVID-19 public health emergency.

We also recommend that CMS go beyond this recommendation and offer additional funding opportunities to support group practices participating, or considering participation, in APMs in 2021. CMS should consider opportunities to offer up-front funding to APMs to support new and continued participation, particularly now as healthcare entities face financial uncertainty and economic downturn. The recently published final report on the ACO Investment Model (AIM) showcases how offering pre-paid shared savings to ACOs to encourage participation can facilitate ACO success in reducing total Medicare spending and related utilization without decreasing the quality of care. CMS estimated a net aggregate reduction in spending of over $381 million across AIM performance years and recouped over half of AIM payments.[10] CMS recently embraced upfront funding opportunities through the creation of the ACO Transformation Track of the Community Health Access and Rural Transformation (CHART) Model, and we encourage the agency to explore additional opportunities to offer similar funding.

MIPS Value Pathways (MVPs)

MVPs: Overview

CMS proposal (85 Fed. Reg. 50279): In 2020, CMS adopted a new framework for MIPS called MVPs, which would organize reporting requirements for each MIPS category around specific specialties, treatments, or other priorities, such as public health. The MVP framework was set to begin in 2021, but CMS proposes to delay this reporting option until 2022.

MGMA comment: MGMA supports delaying implementation of the MVP reporting framework in light of the COVID-19 pandemic. We also support CMS' efforts to create a program intended to: (1) make MIPS more clinically relevant and less burdensome, (2) streamline the four performance categories into a more cohesive program, and (3) create a pathway to Advanced APM participation. However, we are concerned that the MVP framework, as outlined by the agency so far, does not significantly move the needle toward achieving these priorities and instead potentially distracts from efforts to develop APMs.

[10] Evaluation of the ACO Investment Model, Final Report, September 2020.

To improve the MVP framework and aid development, CMS should:

- **Emphasize measures that are meaningful to group practices and their clinicians, rather than administrative claims or population health measures**. Administrative claims measures raise concerns over attribution, retrospective analysis, inability to measure individual physicians, and reliability. Moreover, CMS does not permit stakeholders to propose administrative claims measures, and MGMA believes that MVPs should be constructed from measures that are developed by specialty societies and physician-led organizations.
- **Ensure participation is voluntary.** We are encouraged by CMS' statements throughout listening and feedback sessions inferring that it intends to retain the traditional MIPS reporting framework, as well as the statement in the 2021 PFS preamble that the agency "envision[s] that MVPs will be optional."
- **Support physician specialty societies in their development of MVPs.** CMS should aid MVP development by providing stakeholder groups working on MVPs with claims and QPP data so developers can better understand opportunities for quality and efficiency improvements, educate their members, and provide feedback on program improvements.
- **Implement a gradual transition to MVPs, as the agency did for MIPS, by holding clinicians harmless from a payment penalty for the first two years that MVPs are introduced into the program.** This should be a rolling policy that applies upon implementation of any new MVP, rather than a fixed policy for the first two years of the MVP framework as a whole, since new MVPs will come on board gradually. Alternatively, all physicians who report via the MVP framework should receive a minimum point floor.

MVPs: Subgroup reporting

CMS proposal (85 Fed. Reg. 50280): CMS proposes to update the second guiding principle to allow the option of subgroup reporting for MVPs. If finalized, this approach would allow subgroups of clinicians within one TIN to select an MVP that is meaningful to that particular subgroup and may be different from the MVP or MIPS measures selected by other members of the same group.

MGMA comment: MGMA has generally opposed subgroup reporting in the context of historical quality reporting programs due to concerns that partitioning practices into subgroups could undermine the efficiencies and advantages of the group practice model. Even in the context of MVPs, we remain concerned that, if not implemented correctly, subgroup reporting could result in unintended consequences, such as deterring a team-based approach to patient care, making departments within a group more competitive, and increasing administrative burden. While we understand that, if finalized, reporting at the sub-TIN level would be optional and only available to those selecting MVPs, we are concerned that setting a precedent to divide up group practices solely for the purpose of quality reporting goes against longstanding goals to promote team-based, coordinated care.

However, we also strongly support efforts to create a more clinically relevant program for all clinicians. We recognize that multi-specialty practices, or even specialty groups with sub-specialists, who wish to enjoy the benefits of group level reporting may have a difficult time selecting meaningful measures that apply to all clinicians within the group. This is a common concern cited by MGMA members in certain specialties, who have more broadly raised concerns over the lack of specialty emphasis.

We gathered MGMA member feedback in an effort to better understand how subgroup reporting

might impact group practices now that we are several years into the program and are considering this policy with respect to the MVP framework. We received mixed feedback from a variety of group practices of different sizes, specialties, and affiliations. Overall, there was some support for offering a subgroup reporting option as it may facilitate a more meaningful program for non-primary care specialties, but even those expressing support cautioned that the MIPS program would need to undergo significant changes to make subgroup reporting operationally feasible and to avoid increasing administrative burden on the back end. Because the MVP framework is still undergoing development, we believe there could be changes made to make subgroup reporting a more tenable option and to help the MVP framework realize its goals of making the program more relevant without adding burden.

With this MGMA member feedback in mind, we offer the following for CMS to consider moving forward with this proposal.

- **As proposed, subgroup reporting raises a number of questions and potential complexities for the PI category.** Since each MVP must retain the full set of PI measures, subgroup reporting would apparently require each subgroup to independently fulfill the requirements of PI. MGMA has heard from group practice leaders that certain clinicians within their practice do not typically perform the activities associated with current PI measures, due to their specialty or other unique characteristics. These clinicians have historically relied on the performance of their group practice colleagues to meet PI requirements. Subgroup reporting raises concerns for these clinicians and may deter selection of an MVP with more meaningful quality and measures, since reporting on a separate MVP would also subject them to fulfillment of PI measures. We believe this problem could be mitigated if CMS reforms the PI category within the context of MVPs, as we recommend below.
- **Subgroup reporting would increase reporting burden and complexity unless CMS undertakes more significant efforts to reform MIPS and/or MVPs to reduce administrative burdens.** For example, policies like an increased data completeness threshold for quality measures, full-year reporting for quality, year-over-year changes to the quality measure inventory that reduce the number of available measures, and topped out measure scoring rules could exacerbate reporting burden if a group were to select multiple MVPs. New specialties or site locations within a larger TIN may struggle with data collection in the initial years and have difficulty with full-year reporting at the subgroup level. Moreover, tracking and learning measure specification changes between the time the final rule is released and January, when reporting must begin, is a daunting task. While some subgroups may desire to report separate measures from their colleagues in a different specialty or location, the operational concerns and reporting burden may deter pursuing this option, or worse, result in payment penalties if they begin a performance year by reporting as subgroups and later find it untenable mid-year.
- **Groups reporting at the subgroup level should be held harmless from payment penalties the first few years of implementation.** As groups pursue new data flows, make operational changes, and experiment with new reporting structures/measures, they should be held harmless from a payment penalty. Otherwise, CMS risks significantly disadvantaging practices pursuing innovative reporting options designed to increase clinical relevance and drive quality improvement.

MGMA is uniquely positioned to gather the feedback and input of group practice leaders, executives, and administrators on issues such as subgroup reporting. We stand ready to work with CMS on any

further development of this policy and to help facilitate continued feedback on operational concerns and administrative issues well-known to our members.

MVPs: Digital measures

CMS proposal (85 Fed. Reg. 50281): CMS proposes to add a new guiding principle to the MVP framework, stating: "MVPs should support the transition to digital quality measures. Our future vision for reducing MVP reporting burden; the use of digital performance measure data submission technologies to indicate our commitment to leveraging digital innovations that reduce MIPS related clinician burden. Digital Quality Measures (dQMs) originate from sources of health information that are captured and can be transmitted electronically and via interoperable systems. Examples of digital sources include electronic health records (EHR), health information exchanges (HIEs), clinical registries, case management systems, electronic administrative claims systems, electronically submitted assessment data, and wearable devices."

MGMA comment: MGMA requests additional information on this principle, as CMS does not define what would constitute a "digital measure." In light of this newly proposed principle, we encourage CMS to leverage it through broader recognition of the use of electronic data, such as from wearable devices, and apply MIPS credit for such initiatives.

MVPs: PI category

CMS proposal (85 Fed. Reg. 50281): In discussing MVP development, CMS instructs MVP developers that they should include the entire set of PI measures.

MGMA comment: MGMA opposes the policy to require that MVP developers wholesale adopt the PI category when proposing MVPs, as well as the requirement that groups participating in the MVP framework report for the PI category, just as traditional MIPS reporters do. Even in traditional MIPS, CMS has recognized that certain provider types, such as hospitalists or non-patient facing clinicians, do not have the encounter types that will lead to successful collection of reportable PI data. To accommodate these professionals, CMS created exception policies for certain clinicians, as well as individual measure-level exclusions. While we appreciate these policies within the context of traditional MIPS, the creation of specialty-specific MVPs offers the opportunity to exempt clinicians from irrelevant PI measures at the outset.

The creation of the MVP framework, which endeavors to form a more holistic, less burdensome, and more clinically relevant program, offers CMS an opportunity to reform the PI category, rather than perpetuating reliance on a complicated framework of category and measure-level exceptions and exemptions. We outline two potential approaches for CMS as alternatives to the current policy.

MGMA recommends that CMS permit groups reporting via the MVP framework to attest that they (or at least 75% of the eligible clinicians in their group) are using CEHRT or health IT that interacts with CEHRT. This policy would align with requirements for models to qualify as an APM, which is consistent with CMS' goals for the MVP framework to create a more viable pathway to APM participation.

This approach would meet the statutory requirements of 42 U.S.C. 1395w–4(o)(2)) if group practices attest that they are using CEHRT to e-prescribe for at least one patient and exchange health information on at least one patient. Further, the HITECH Act, as amended by MACRA, provides CMS discretion to allow a professional to satisfy demonstration of meaningful use through attestation.[11]

[11] 42 U.S.C. 1395w–4 (o)(2)(c)(i)(I).

Alternatively, CMS should permit MVP developers to outline digital measures and/or CEHRT functionalities that could meet PI category requirements. This approach would recognize use or implementation of digital tools or other technological pursuits that align with the clinical and quality goals of the individual MVP, offering a more cohesive program as intended. Developers could come up with measures that meet the statutory requirements for meaningful use of EHR technology but that comport with the unique characteristics of that particular specialty or MVP focus. The MVP could describe how clinicians would use CEHRT or health IT that interacts with CEHRT as part of their management of patient care for the MVP. Group practices and clinicians reporting via the MVP would be required to attest "yes/no" to utilizing those functionalities.

We offer these alternative policies because the objectives and measures included in the existing MIPS PI category are not clinically relevant or operationally feasible in every group practice. The wholesale retention of this category is counter to the very intent of MVPs to create a more streamlined, less burdensome, and more clinically tailored reporting program.

MVPs: Transition to APMs

CMS proposal (85 Fed. Reg. 50282): One of the guiding principles for MVPs is that MVPs should "reduce barriers to APM participation." Further, in outlining MVP development criteria, CMS proposes to consider whether the MVP acts as a vehicle to incrementally phase clinicians into APMs.

MGMA comment: MGMA supports easing the transition into APMs and efforts to reduce barriers to APM participation. However, based on MVP policies outlined so far, it is unclear how reporting an MVP would facilitate moving into or prepare for participation in an APM. We encourage CMS to work with specialty societies and stakeholders, including those working to develop APMs, on how to improve the MVP framework such that it more meaningfully aligns with APMs.

By definition, APMs feature different payment structures than traditional fee-for-service; while some models retain aspects of the fee-for-service system, they offer rewards not available outside of APMs for efficient use of Medicare services, quality outcomes, and leveraging services that are not traditionally reimbursed by Medicare, such as care coordination efforts. Additional payment mechanisms available under the APM, such as shared savings payments or care management fees, fund the value-based efforts of the APM, creating an investment cycle. Such funding opportunities are not available for MVP reporters, as MIPS does not make impact payments until two years after the applicable performance year.

Further, APM participants can avail themselves to waivers that permit the types of activities that are necessary for success in value-based care, such as greater flexibility to offer telehealth services, coordinate care across different provider types without running afoul of fraud and abuse laws, offer beneficiaries incentives to promote better health outcomes, and share resources across APM participants.

In summary, APMs address key flaws within the fee-for-service system. This includes providing payment for high-value services; leveraging nurses, clinical personnel, and staff to provide patient care coordination; paying attention to socioeconomic barriers to care or outcomes; coordinating care across specialties and primary care; investing in and leveraging use of technology resources, such as access to ADT feeds, to coordinate appropriate follow-up care; and other patient-centric initiatives. We encourage CMS to consider the activities and infrastructure necessary to succeed in APMs and evaluate how MVPs can help prepare clinicians for these changes.

MIPS APMS

Eliminating the MIPS APM standard in lieu of the APP

CMS proposal (85 Fed. Reg. 50285): CMS proposes to eliminate the APM scoring standard for MIPS starting in 2021 and replace it with a new, voluntary reporting structure called the APP. APMs could report via the APP or choose one of the options available in traditional MIPS (e.g., reporting as a group, virtual group, or individual).

The scoring policies for cost and improvement activities would generally be the same under the APP as the current policies under the MIPS APM scoring standard. Specifically, the APP would not score participants on cost and would assign an improvement activity score to APP reporters based on model specifications (which would result in full credit for all APMs opting-in to the APP in 2021). The PI performance category would be reported and scored at the individual or group level, as is the case for MIPS reporting. The quality category under the APP would be composed of a fixed set of six measures: three clinical measures, two administrative claims measures, and one measure with a composite score for CAHPS.

MGMA comment: We do not support the proposal to retire the MIPS APM scoring standard and oppose moving to the APP in 2021. We are particularly concerned about the potential negative impact this proposal would have on non-ACO MIPS APMs and instead recommend that CMS take more time to consider stakeholder feedback on how to best measure APMs subject to MIPS reporting. Further, as an overarching recommendation, we also encourage CMS to consider how to move more APM participants away from MIPS all together and into the Advanced APM track of the QPP, as was Congress's intent when enacting MACRA. For example, CMS could modify its financial risk standard to allow more APMs to meet the definition of an Advanced APM and modify its policies around QP thresholds to add more flexibility into the patient count threshold, as is permitted by MACRA.

MGMA is concerned with how the APP framework would impact APM participants with respect to quality measure reporting, since the APP quality measure set would require that all MIPS APMs report the same measures, regardless of the model's specialty focus. This policy is counter to CMS' goals in other areas of the program, such as MVPs and specialty measure sets, to make MIPS more clinically relevant to specialists. In contrast to the APP, the current MIPS APM scoring standard recognizes that each APM has its own set of unique quality measures and scoring policies.

Reporting via the APP would require an APM (besides MSSP participants) to submit two separate quality measure sets: one for their own model evaluation and a second set of APP measures for MIPS. This would increase administrative burden for MIPS APMs and does not further the goals of agency's Patients over Paperwork initiative, nor the Administration's broader efforts to reduce regulatory burden.

We recognize that under CMS' proposal, APMs could forgo reporting via the APP and instead report under traditional MIPS, thereby enabling them to select potentially more relevant quality measures from the traditional MIPS inventory. However, subjecting APMs to traditional MIPS scoring policies does not recognize the work APM participants do within their own model to further cost-efficient, coordinated care. Specifically, choosing to report for traditional MIPS would subject APM participants to measurement on cost category measures, while concurrently holding them accountable for cost benchmarks or reduction efforts that are inherent goals of their model; it would also apparently entail submission of improvement activities, rather than affording them automatic credit as is the current policy. MGMA believes that this is counter to the agency's mission to promote APM participation.

While the APP quality measures may be clinically relevant to ACOs and primary-care focused APMs, they are not relevant to specialty-focused APMs, such as participants in the Bundled Payments for Care Improvement Advanced (BPCI-A) model. For example, a group practice

participating in BPCI-A informed us that two of the measures proposed for inclusion in the APP, the diabetes screening (Quality ID 001) and depression screening (Quality ID 134) measures, are not clinically relevant to their neurosurgery practice. Furthermore, they have never administered CAHPS surveys before, and doing so now would require added expenses and changes to patient workflows. This member practice stated that the quality measures they report for BPCI-A, including advance care planning (NQF 0326) and perioperative antibiotics (NQF 0268), currently work well for their practice, are clinically relevant, are familiar to them, and satisfy model criteria. Subjecting practices like this group to either the APP measure set, which includes primary care-focused measures they are not familiar with, or the traditional MIPS scoring standard is unfair and is not moving the QPP in the right direction.

We further submit that episodic, specialty-focused models, such as BPCI-A and Comprehensive Care for Joint Replacement (CJR), have generally been required to report for MIPS, based on our review of available data and anecdotal feedback from past performance years, rather than enjoy the benefits of the Advanced APM track, due to existing policies around attaining qualifying participant (QP) status that make it exceedingly difficult for them to achieve even partial QP status. We learned from members in BPCI-A and CJR that they have not achieved even *partial* QP thresholds in past years, meaning they must report for MIPS or face a payment penalty. The QPP Experience Reports released to date confirm these anecdotal reports concerning low QP thresholds, at least with respect to the CJR model (since BPCI-A data was not included in any report to date): in each year, aggregate results show the average payment threshold has not exceeded 13% and average patient threshold was just 5% in both years.[12] Therefore, until QP threshold policies can be fixed, we urge CMS to put additional thought into how to make the MIPS program more meaningful to these practices, rather than disadvantaging them and failing to recognize their work through the APM toward furthering high quality, cost-effective care.

In addition to concern over the quality measure set proposed for the APP, we are concerned with proposals that would align APM and non-APM measurement. By eliminating the Web Interface option, which is predominantly used by APM participants, APMs would select eCQM or CQM and be measured against non-APM participants that also select that reporting option. By using the same measure benchmarks to evaluate performance of APM and non-APM participants, CMS may disadvantage groups that are not part of an APM. APM participants have different resources they can leverage and policies in place to improve quality performance, which may not be available to the typical group practice. As evidenced in the experience reports released to date for the 2017 and 2018 reporting years, MIPS APM participants traditionally score higher than non-MIPS APM group practices.

Quality Category

CMS Web Interface

CMS proposal (85 Fed. Reg. 50288): CMS proposes to end the Web Interface as a quality reporting option for ACOs, APM entities, groups, and virtual groups starting in 2021.

MGMA comment: We encourage CMS to delay the proposal to sunset the Web Interface as a reporting option by at least one year.

This proposal does not allow sufficient time for groups that used the Web Interface to implement the necessary changes. These groups must generally choose between CQM, eCQM, or QCDR, which will necessarily entail changes to operational workflows and will likely entail upfront expenses from purchasing additional EHR functionalities or registry fees, depending on the submission mechanism

[12] 2017 QPP Experience Report, Table 7; 2018 QPP Experience Report, Table 7.

selected.

Given that the final rule may not be released until December, this means groups would have around 30 days to consider a new reporting mechanism, engage in any necessary supplemental contracts, pay additional expenses, learn new measure flows, and educate clinicians and staff on any operational changes. Given that the COVID-19 pandemic is expected to demand continued attention and impact the financial health of group practices, at least for the next several months and into 2021, MGMA strongly encourages CMS to not add extra burden on groups that report using the Web Interface at this time and to delay retiring this reporting mechanism by at least one year.

Quality measure benchmarks

CMS proposal (85 Fed. Reg. 50307): Generally, CMS uses historical benchmarks to score quality measures based on performance data gathered two years before the performance year. For the 2021 performance period, CMS proposes to use 2021 performance period benchmarks to score quality measures due to concern there will not be a representative sample of historic data from 2019 because of the national COVID-19 pandemic.

MGMA comment: MGMA appreciates CMS' forethought that 2019 benchmarks may be unreliable or skewed due to the COVID-19 pandemic. However, we have concerns about using current year (2021) performance data to formulate quality benchmarks. Establishing benchmarks that are stable, reliable, and valid is critical and will better ensure that clinicians are able to engage in a meaningful and useful way. We believe clinicians and group practices should have time to understand how their performance compares to benchmarks and to adjust performance based on these comparisons. Moreover, if there is no predetermined benchmark, clinicians will not be aware if a measure they opted to report is considered topped out and subject to a scoring cap. We recommend that CMS carefully review 2019 data to determine whether or not it could be used to calculate valid historic benchmarks before moving forward with its proposed policy to use 2021 benchmark data.

Removing quality measures

CMS proposal (85 Fed. Reg. 50307): CMS proposes to remove measures due to low adoption, topped out status, or potential duplication.

MGMA comment: In general, MGMA urges CMS to exercise caution when removing measures to avoid disadvantaging certain specialties or submission types. Reducing the quality measure inventory limits flexibility in selecting measures and can force clinicians into selecting less clinically relevant measures. It is difficult enough for certain specialties to find six quality measures on which to report. CMS should take a more deliberate approach to measure removal and work with measure stewards to determine if removal is appropriate.

As stated in previous comment letters, MGMA opposes removing measures with low reporting rates as well as topped out measures. Removing measures due to low reporting rates discourages the development of new quality measures. New measures will not have a historic benchmark for two years; thus, by removing a measure after two years of low reporting, CMS is not allowing the opportunity to develop a benchmark for new measures. In short, a measure may have a low reporting rate *because* it lacks a benchmark, rather than the measure not being a meaningful metric to clinicians.

When CMS removes a measure from the quality inventory, it must engage in a comprehensive education and outreach campaign to provide sufficient notice to physician group practices. In addition to labeling extremely topped out measures in all measure appearances, including on the QPP website and in the benchmark spreadsheet, CMS should notify physicians and groups in their

feedback reports about whether any of the measures they submitted have been deemed extremely topped out. We urge CMS to work with data submission vendors to provide feedback to group practices that select extremely topped out measures and to provide feedback in the remittance advice to clinicians who submit data about an extremely topped out measure via claims.

Quality administrative claims measures

CMS proposal (84 Fed. Reg. 40750): CMS proposes two new administrative measures: (1) Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS groups, and (2) Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for MIPS clinicians.

The HWR measure would replace the all-cause readmission measure and would continue to apply only for groups or virtual groups with 16 or more clinicians that meet the case minimum of 200 over a one-year measurement period. The new RSCR measure following a THA or TKA could apply to individuals, as well as groups/virtual groups, that meet a case minimum of 25 over a three-year measurement period.

MGMA comment: MGMA urges CMS not to introduce new mandatory measures for the 2021 performance year. Clinicians and group practices need stability now more than ever, and this is not the time to add new metrics, particularly to a category that groups are familiar with already. Moreover, as a general matter, we have significant concerns around administrative claims measures. While CMS asserts these measures do not increase reporting burden since they are calculated on clinicians' behalf, it takes time to study the measures themselves, understand how clinicians are evaluated, and determine how (or if) clinicians can influence performance. With registry or EHR reporting, clinicians can receive real time feedback on measure performance and evaluate whether changes are needed to facilitate improvement. Claims-based measures do not offer the same opportunity, which makes it difficult to improve performance or drive meaningful change.

MIPS Cost Performance Category

CMS proposal (85 Fed. Reg. 50293): CMS proposes to increase the cost performance category weight by 5%, up to 20% overall, in 2021.

MGMA comment: MGMA is strongly opposed to increasing the weight of the cost category in 2021. MGMA appreciates that CMS' intent is to prepare clinicians for 2022, when CMS is required to weight the quality and cost categories at 30%, respectively. However, we recommend against increasing the weight of the cost category during the COVID-19 public health emergency. We expect that the pandemic will continue into 2021, requiring group practices to continue to focus on adjusting to unusual and unpredictable patient volumes, maintaining heightened safety protocols, and sustaining their practices. In addition, since cost measures rely on national average benchmarks, we are concerned that practices in COVID-19 hot spots, who have been treating, testing, and fighting the pandemic, will be unfairly penalized. If the public health emergency causes disruptions to attribution, reliability, validity, or would adversely impact physicians on the frontlines of the pandemic, we urge CMS to reweight the cost performance category to zero.

In addition to the foregoing, we have outstanding concerns regarding key aspects of the cost category. MGMA continues to urge CMS to discontinue measuring clinicians on the total per capita cost (TPCC) and Medicare spending per beneficiary (MSPB) measures due to longstanding concerns that these measures unfairly penalize providers by holding them accountable for costs they cannot control. If CMS retains these measures, then we urge the agency to revise them to correct flawed attribution and insufficient risk-adjustment methodologies. While we appreciate efforts undertaken by CMS to improve these measures, additional work is needed.

One of our most significant concerns with this category is regarding patient attribution. MGMA members have shared reports of providers being attributed high-cost patients they saw only a handful of times for inexpensive services. For example, one specialty practice had several high-cost patients attributed to non-physician practitioners, who cannot designate a Medicare specialty and be exempted from attribution. This practice reported that their clinicians saw select patients less than five times each in a given performance year for inexpensive services, yet they were held responsible for their entire cost of care, which included costly episodes. We encourage CMS to evaluate ways to recognize specialty exclusions for non-physician practitioners to avoid this issue in the future.

MGMA also urges CMS to increase the reliability threshold. CMS has admitted that 0.4 reliability is on the low end of the reliability spectrum but justifies low reliability as a tradeoff for higher variation among clinicians and groups. We see no reason why the application of low-validity measures to more clinicians and groups outweighs concerns about reliability.

Lastly, the lack of robust feedback on resource use makes it extremely difficult for clinicians and group practices to familiarize themselves with cost measurement and undertake efforts to improve cost efficiency. One of the most common concerns raised by MGMA members regarding the MIPS program is that they have no ability to influence cost measurement and that attribution methodologies are unfair, confounding, and inappropriate. MGMA members inform us that despite reviewing the materials made available by CMS and endeavoring to understand evaluation and patient assignment, they struggle to link evaluation with actions they can take to improve cost efficiency, leading to the sentiment that they have no influence over controlling costs. It is critical that the agency provide timely and actionable specifications regarding these measures, particularly as methodologies change year-over-year and new measures are added. We encourage CMS to provide comparative information, such as the number of procedures a clinician performs comparative to peers, as well as information regarding the costs of certain episodes of care, such as procedures or visits following a procedure. We have heard from MGMA members that this type of comparative data is helpful in cost reduction, as clinicians can see where they fall on utilization compared to their peers. Improving feedback and transparency around cost measure methodologies and evaluation would also aid MVP development, permitting developers to better understand relevant cost measures for MVPs that are meaningful and understandable to clinicians.

MIPS Improvement Activities Category

CMS proposal (85 Fed. Reg. 50294): CMS proposes to generally maintain 2020 policies for the improvement activities category.

MGMA comment: MGMA supports efforts by the agency to create stable, consistent policies for the improvement activities category. MGMA appreciates that CMS established a new, high-weighted activity for participation in COVID-19 clinical trials, and we encourage CMS to create additional qualifying activities to incentivize and recognize clinicians for participating in additional COVID-19-related efforts.

MIPS Promoting Interoperability Category

Reporting period

CMS Proposal (85 Fed. Reg. 50278): "We propose in section IV.A.3.c.(4) of this proposed rule, to establish a performance period for the PI performance category of a minimum of a continuous 90-day period within the calendar year that occurs 2 years prior to the applicable MIPS payment year, up to and including the full calendar year, for the 2024 MIPS payment year and each subsequent MIPS payment year…"

MGMA comment: We thank CMS for continuing the 90-day reporting period and encourage CMS to further align the PI programs for the Medicare and Medicaid programs through common measures and reporting periods. By providing continued program stability, CMS allows clinicians and groups to focus more on caring for patients and improving interoperability and less on prescriptive reporting requirements.

CEHRT edition

CMS proposal (85 Fed. Reg. 50267/50271): "As a result, where the 21st Century Cures Act final rule requires health IT developers to make technology meeting new and updated certification criteria available by May 2, 2022, developers taking advantage of enforcement discretion would be permitted to delay making updated certified technology available until August 2, 2022… After that date, technology that has not been updated in accordance with the 2015 Edition Cures Update will no longer be considered certified."

MGMA comment: CMS proposes that eligible clinicians and groups participating in the PI programs must use technology certified under the Office of the National Coordinator for Health Information Technology (ONC) Certification Program according to the timelines finalized in the 21st Century Cures Act Final Rule. CMS also proposes that after August 2, 2022, technology that has not been updated in accordance with the 2015 Cures Update Edition will no longer be considered certified.

It is clear that CMS has not adequately considered the implications of having the identical timeline for both software developers and end user practices to migrate to the 2015 Cures Update Edition EHR. CMS has proposed an August 2, 2022, adoption deadline for physicians to use 2015 Cures Edition EHR. This is the same amount of time EHR vendors will have to make 2015 Cures Update Edition EHRs available to practices. Common sense would dictate that software being made available by the vendor and implementation of the EHR by the practice cannot occur on the same date. Practice vetting, acquisition, implementation, customization, and staff training typically takes from 12-24 months, depending on the vendor, whether the installation is an upgrade from a previous edition or new installation, and practice resources. It is imperative that CMS build in this additional time following the final date software developers have been granted by ONC to meet the 2015 Cures Update Edition certification.

CMS proposal (85 Fed. Reg. 50268): For updated and new certification criteria included in the CEHRT definitions in sections 495.4 and 414.1305, ONC has finalized that health IT may be certified to the current 2015 Edition certification criteria or the 2015 Edition Cures Update for a period of 24 months, as described in timelines finalized in the 21st Century Cures Act final rule (85 FR 25670). ONC then announced an additional 3 months during which ONC will exercise enforcement discretion in response to the COVID–19 public health emergency and continue to allow health IT certified to either version of the criteria to be considered certified. Therefore, under our proposal, during that same time period (up to 27 months from May 1, 2020, or until August 2, 2022), program participants may use technology certified to either version and that health IT will be considered certified under the ONC Health IT Certification Program.

MGMA comment: After August 2, 2022, the agency is proposing technology that has not been updated in accordance with the 2015 Edition Cures Update will no longer be considered certified and eligible clinicians and groups using this technology will be unable to score points in the PI category. While the ONC has announced an additional 3 months during which ONC will exercise enforcement discretion in response to the COVID–19 public health emergency and continue to allow health IT certified to either version of the criteria to be considered certified, we do not believe this is sufficient. CMS is making a determination, in the midst of the COVID-19 public health emergency, that mid-

way through the year in 2022 software developers will have completed modifications and have been certified to the 2015 Cures Update Edition practices will be at the point where they are able to afford what are expected to be costly upgrades.

We assert that CMS should adopt a more measured approach to CEHRT requirements. Many expect the COVID-19 public health emergency and its economic impact to last well into 2021 and perhaps even into 2022. Understanding this, should CMS not extend the time ECs and groups have to implement 2015 Cures Update Edition CEHRT the 12-24 months we recommend above, we urge the agency to permit 2015 Edition CEHRT to be used, at a minimum, through CY 2022. As an incentive for practices to adopt 2015 Cures Update Edition CEHRT, CMS can offer PI bonus points and/or include the use of 2015 Cures Update Edition CEHRT as an Improvement Activity.

In addition, we urge CMS to work closely with ONC over the next two years to track the number of vendor products that are being certified to the 2015 Cures Update Edition. We are concerned that the impact of the COVID-19 public health emergency coupled with the challenging new ONC certification requirements could result in many products not being recertified to the 2015 Cures Update Edition. This would then force practices to either "rip and replace" their current EHR software at great expense, inconvenience, and with the potential of patient safety being impacted, or withdraw their participation from the QPP. Should there be fewer EHR products in 2022 certified at the 2015 Cures Update Edition level than the 2015 Edition level, we urge CMS to continue permitting 2015 Edition CEHRT to be used by program participants through CY 2023.

PDMP measure

CMS Proposal (85 Fed. Reg. 50298): "We are also proposing for the performance period in CY 2021 to increase the amount of the bonus points for the Query of PDMP measure from 5 points to 10 points to reflect the importance of this measure and to further incentivize clinicians to perform queries of PDMPs."

MGMA comment: We support the increase in the amount of the bonus points for the Query of PDMP measure from 5 to 10 points. PDMP is a proven means to increase accountability in opioid prescribing practices by providing information directly to the clinician that facilitates the coordination of multiple medications. It has also been proven to help prevent adverse drug interactions. We concur that PDMPs increase patient safety by assisting prescribers in the identification of patients who have multiple prescriptions for controlled substances or may be misusing or overusing them. Expanding the use of PDMPs is a component of a broader strategy to prevent opioid abuse and ensure the safe, legal, and responsible prescribing of opioids for those who need them. We agree that improving prescribing practices by use of PDMPs should reduce hospitalizations, emergency room visits, and the social challenges associated with the opioid epidemic.

HIE objective

CMS Proposal (85 Fed. Reg. 50300): "In order to incentivize MIPS eligible clinicians to engage in bi-directional exchange through an HIE, we are proposing to add the following new measure under the HIE objective beginning with the performance period in 2021: Health Information Exchange (HIE) BiDirectional Exchange measure. We propose to add this new HIE BiDirectional Exchange measure to the HIE objective as an optional alternative to the two existing measures: The Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure. We are proposing that clinicians either may report the two existing measures and associated exclusions OR may choose to report the new measure. We propose that the HIE Bi-Directional Exchange measure would be worth

40 points. In no case could more than 40 points be earned for the HIE objective."

MGMA comment: We support adding a Health Information Exchange BiDirectional Exchange measure as an optional alternative to the two existing measures. We also support permitting clinicians to report this one measure and receive the full complement of 40 points, and we agree that the best reporting approach is attestation (yes/no response). We concur that as more and more practices are interacting with their local HIEs, adding this new measure to the PI category will be a clear incentive for practices to seek out and establish these important connections.

However, this measure is significantly more expansive than combining the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure. We are concerned that this Bi-directional exchange requires that the clinician's EHR is enabled to allow for querying and sharing data by sending, receiving, and incorporating data via an HIE for every patient. To successfully attest to the new measure, the eligible clinician or group must establish the technical capacity and workflows to engage in bi-directional exchange via an HIE for all patients seen by the eligible clinician and for any patient record stored or maintained in their EHR. This includes querying for or receiving health information for all new and existing patients seen by the eligible clinician, as well as sending or sharing information for all new and existing patients seen by the eligible clinician, regardless of known referral/transition status or the timing of any potential transition/referral.

There is no partial credit proposed for this measure. The new optional measure would require that bi-directional engagement occurs for all patients and for all patient records. As this measure is new and robust connections with HIEs are still rare, we contend that this is an unreasonable requirement and recommend for the CY 2021 reporting year that it be modified to be "a minimum of 10 percent of patient encounters and for a minimum of 10 percent of patient records transmitted during the performance period."

Further, we urge CMS in the future to ensure that clinicians continue to have multiple options to meet the Health Information Exchange measure, as not all clinicians will have access to an HIE. The other issue facing practices can be the cost of connecting with their local exchanges. High connectivity fees imposed by the HIE and/or the practice's EHR vendor can act as a significant deterrent to connectivity. Especially considering the new financial challenges associated with the COVID-19 public health emergency, practices participating in MIPS should not be penalized for not having sufficient financial resources to meet an overly prescriptive Health Information Exchange measure.

HIE Bi-Directional Exchange measure

CMS Proposal (85 Fed. Reg. 50300-50301): "We are proposing the HIE Bi-Directional Exchange measure would be reported by attestation and would require a yes/no response. As we believe that fulfillment of this measure is an extremely high value action, a ''yes'' response would enable the clinician to earn the 40 points allotted to the HIE objective. We propose that clinicians would attest to the following: ++ I participate in an HIE in order to enable secure, bi-directional exchange to occur for every patient encounter, transition or referral, and record stored or maintained in the EHR during the performance period. ++ The HIE that I participate in is capable of exchanging information across a broad network of unaffiliated exchange partners including those using disparate EHRs and does not engage in exclusionary behavior when determining exchange partners. ++ I use the functions of CEHRT for this measure, which may include technology certified to criteria at 45 CFR 170.315(b)(1), (b)(2), (g)(8), or (g)(10)."

MGMA comment: While we agree that a "yes/no" attestation to meeting the measure requirements

is appropriate, we have concerns with the attestation statements as proposed. In terms of the first attestation statement, as stated above, we do not believe it is reasonable to insist that the "secure, bi-directional exchange occur for every patient encounter, transition or referral, and record stored or maintained in the EHR during the performance period." The first attestation statement should be modified to read, "I participate in an HIE in order to enable secure, bi-directional exchange to be available for patient encounters, transitions or referrals, and for records stored or maintained in the EHR during the performance period."

The second attestation statement, "The HIE that I participate in is capable of exchanging information across a broad network of unaffiliated exchange partners including those using disparate EHRs, and does not engage in exclusionary behavior when determining exchange partners," requires the practice to have knowledge about the HIE that is impossible for them to have. We recommend the statement be modified to read, "To the best of my knowledge, the HIE that I participate in is capable of exchanging information across a broad network of unaffiliated exchange partners including those using disparate EHRs, and does not engage in exclusionary behavior when determining exchange partners."

The third attestation statement, "I use the functions of CEHRT for this measure, which may include technology certified to criteria at 45 CFR 170.315(b)(1), (b)(2), (g)(8), or (g)(10)," could be confusing to clinicians and groups and could require technical knowledge beyond the capability of some smaller organizations. We recommend the statement be modified to read, "To the best of my knowledge, I use the functions of CEHRT for this measure, which may include technology certified to criteria at 45 CFR 170.315(b)(1), (b)(2), (g)(8), or (g)(10)."

CMS proposal (85 Fed. Reg. 50301): "We invite comments on these proposals, and whether commenters believe such an optional measure would incentivize eligible clinicians to participate in HIEs while establishing a high-performance standard for sharing information with other clinicians… Do these statements reflect appropriate expectations about information exchange capabilities for eligible clinicians that engage with HIEs capable of facilitating widespread exchange with other health care providers? How should CMS effectively identify those HIEs that can support the widespread exchange with other health care providers? How are eligible clinicians currently using CEHRT to exchange information with HIEs, and do the proposed attestation statements allow for different ways health care providers are connecting with HIEs utilizing certified health IT capabilities?"

MGMA comment: We agree that state and regional HIEs typically obtain not just EHR-generated data, but a broader array of admit, discharge, and transfer feeds and lab feeds, as they build on local provider relationships. In addition to these HIE initiatives, some EHR vendors are participating in the development of national-level networks designed to facilitate the sharing of information between their clients and the clients of other vendors. This can result in practices receiving information that improves the care delivery process.

HIEs facilitate broader interoperability beyond a single health system or point-to-point connections among providers, payers, and the patients themselves. By enabling a bi-directional exchange of information between healthcare providers and aggregating data across providers with disparate systems, HIEs have the ability bring together the information needed to create a true longitudinal care record and support improved care coordination by permitting timely access to health information across care settings. Bi-directional exchange means that the clinician's EHR is enabled to allow for querying and sharing data by sending, receiving, and incorporating data via an HIE for their patients.

In terms of the maturity rate of HIEs, while there are a significant number of HIEs across the nation that we believe would meet the standards described in the attestation statements, some HIE

arrangements may not have the capacity to enable bi-directional exchange for every patient transition or referral made by a clinician. For this reason, such HIEs would not meet the proposed standard described in the attestation statements required to fulfill the measure.

In an effort to further incentivize provider participation in HIEs, we recommend broadening the definition of an acceptable HIE for purposes of this measure. CMS is excluding from the measure exchange networks that only support information exchange between affiliated entities, such as "health care providers that are part of a single health system, or networks that only facilitate sharing between health care providers that use the same EHR vendor." We disagree with this approach. For at least the first year, clinicians and groups that are part of a single health system or networks that share data only between providers that use the same EHR vendor should be permitted to utilize the measure.

Security Risk Analysis measure

CMS proposal (85 Fed. Reg. 50302): "The Security Risk Analysis measure is required, but will not be scored."

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

The HIPAA security regulation outlines the required process but does not specify the exact steps, milestones, or expected outcomes of that analysis. Consequently, compliance with this requirement and fulfillment of this current PI requirement has proven difficult, especially for smaller practices that typically have limited in-house expertise in this area. CMS should work with the Office for Civil Rights (OCR) to develop specific guidance and education on risk analysis and risk mitigation. In particular, we would encourage full transparency from those agencies that conduct audits of practice security processes and procedures. Having CMS (through Figliozzi), OCR, and the Office of Inspector General provide comprehensive details of audit processes and de-identified findings will be essential for practices to understand the government's risk analysis requirements and expectations.

We further recommend CMS provide physician practices with guidance on the various available security frameworks and how to implement them to protect electronic PHI through administrative, physical, and technical safeguards (as required under HIPAA). While many security frameworks exist, the healthcare industry has not reached a consensus on 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.

PI scoring

CMS proposal (85 Fed. Reg. 50305): "For the 2023 MIPS payment year, we intend to continue to build on the scoring methodology we finalized for prior years."

MGMA comment: We are disappointed that the agency has proposed to continue the "all or nothing" methodology for the MIPS PI category as required in previous iterations of EHR reporting programs. Instead of rewarding clinicians and groups for using EHR technology to treat their patients, the proposed rule outlines a continued approach that penalizes an EC for missing even one of the objectives by giving them zero points in the PI category. We urge CMS to discontinue this tactic and permit clinicians to score points in any of the PI measures.

Reweighting policies

CMS proposal (85 Fed. Reg. 50359): "In this proposed rule, we are not proposing any changes to our current criteria for automatic reweighting of the Proposed Rules PI performance category for certain MIPS eligible clinicians or MIPS eligible clinicians who have experienced a significant hardship or decertification of an EHR."

MGMA comment: As stipulated in the 21st Century Cures Act, clinicians are permitted to apply for a hardship exception should their EHR be decertified by ONC. We support the CMS policy of relying on this statutory provision to assign a 0% weighting to the PI category for clinicians and groups who demonstrate that reporting PI measures is not possible because the CEHRT used was decertified. When a physician practice invests in an EHR that has been subsequently decertified and thus cannot be leveraged for MIPS participation, the process of determining next steps vis-à-vis technology will be long and complicated. Vendors who have been decertified may still attempt to be recertified and most likely will communicate this to their clients, further complicating the decision-making process.

We are concerned, however, with the agency's current requirement that the MIPS eligible clinician "make[s] a good faith effort to adopt and implement another CEHRT in advance of the performance period." Typically, practices would prefer not to have to switch to a new EHR and therefore may lose significant time in evaluating whether there is a need to select a new product. Further, once the practice does decide that it must switch to another software product, that EHR selection process can take a significant amount of time – considerably longer than the "in advance of the performance period" identified in this proposed rule. To rush the selection and implementation of an EHR puts the practice at risk of not only impacting practice performance, but also patient safety. Also, when practices adopt a new EHR, they often move to new practice management system software as well (usually an integrated product), which incurs additional costs and time for implementation and testing. These challenges are exacerbated in smaller practices, which have fewer resources to implement new software and train staff.

With these issues in mind, we urge the agency to remove the requirement that clinicians make a good faith effort to adopt and implement another CEHRT in advance of the performance period, permit the eligible clinician to receive a hardship exception for as long as they require it, and reweight the clinician's PI performance category to zero.

While we support the existing hardship exceptions for 2021 and continue to support the agency's plan to reweight the PI category to zero, we also have the following comments and recommendations for CMS:

- 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 clinicians and group practices who experience unforeseen circumstances, rendering it impossible to demonstrate the PI requirements during the

reporting period through no fault of their own, to a minimum of five years after they begin experiencing these circumstances.

- Add a new hardship exception for clinicians and group practices who have switched from one EHR product to another or experience significant difficulties with their EHR.
- Expand the hardship exception for clinicians and group practices that have been in practice for a limited period to allow them the additional time to identify, acquire, and implement the most appropriate EHR technology. In addition, we recommend the exception be expanded to include those clinicians and group practices who have changed specialty taxonomy.
- Grant clinicians eligible for Social Security benefits a hardship exception, and do not subject them to any Medicare payment adjustment. Meeting the PI requirements requires considerable expenditures of both human and financial capital, and the return on investment of an EHR installation to support MIPS likely will require several years of operation.
- Simplify the hardship exception application process by permitting multiple application submission options, including mail, fax, and online capabilities. This would allow clinicians and group practices additional flexibility for submitting applications.
- Provide email receipt confirmation once a hardship application has been submitted by a clinician or group practice. 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.

Lastly, we wish to comment on instances when software issues hinder or prevent data reporting. Over the past two years, we have heard from numerous members that they experienced significant issues with their practice management system software and that these issues impacted their ability to submit MIPS data to CMS. In many cases, these software issues were discovered by the practice late in the year, too late to start over with a new 90-day reporting period. These vendor issues were reported to CMS, but the agency took no action to hold the clinicians and groups harmless from any associated Medicare payment penalties. We recommend CMS not impose Medicare payment penalties when clinicians and groups make a good faith effort to submit MIPS data yet are prevented from successfully participating in the program due to a software failure.

Future direction of the Medicare PI program

CMS proposal (85 Fed. Reg. 50303): CMS states it will consider future changes to the PI program that support a variety of HHS goals.

MGMA comment: While we appreciate the intent of 2021 PI policies to decrease the administrative challenges associated with clinicians participating in the PI component of MIPS, implementation of the proposed approach could act as a deterrent to clinician participation and a roadblock to success of the program. By 2021, many clinicians would have been utilizing CEHRT for close to a decade as part of a CMS incentive program. Requiring objectives for the PI score (Security Risk Analysis, e-Prescribing, Provider to Patient Exchange, and Health Information Exchange) adds an unnecessary burden for clinicians and groups participating in MIPS. The Security Risk Analysis has been a legal requirement since 2005 and the remaining three objectives are each fundamental functions of 2015 Edition CEHRT.

For future PI reporting, clinicians or groups could simply attest to implementing 2015 Edition or 2015 Cures Edition CEHRT and that they have not turned off any of the PI features. Completion of these attestations by participants would be deemed to have met the PI requirements and they would be awarded the full category credit. Rather than have CMS and ONC dictate how eligible clinicians

should leverage their technology to treat their patients, we urge these agencies to permit eligible clinicians to work directly with their EHR vendor and provider colleagues to develop and implement the infrastructure and workflow necessary to effectively and efficiently exchange patient data.

The agency should also consider maximizing the ability of eligible clinicians and groups to leverage technology to meet multiple MIPS requirements. Optimally, those clinicians and groups attesting to successfully participating in one or more of the improvement activity options that require the use of CEHRT or successfully reporting quality measures using CEHRT should be deemed to have met the PI requirements and be awarded full category credit.

Should this cross-category approach to meeting program requirements not be adopted, we recommend a methodology where the PI component of MIPS would cease being an "all or nothing" approach with participants able to select among the measures within an objective that best meets their clinical needs. This would permit them to score points in any of the categories – selecting measures that are most relevant to their patient population and within their control. Clinicians and groups could also be incentivized to adopt 2015 Cures Edition CEHRT with 20 points automatically added to their PI score. Finally, we also believe that removing the administrative requirements associated with meeting superfluous objectives would be a further incentive for physician practices to adopt CEHRT.

MIPS Final Score and Payment Adjustments

MIPS complex patient bonus

CMS proposal (85 Fed. Reg. 50310): CMS established a complex patient bonus of up to five points through the 2018 final rule and continued the bonus for the 2019 and 2020 performance periods. The bonus was intended to "serve as a short-term strategy to address the impact patient complexity may have on MIPS scoring" as the agency works with stakeholders on "methods to account for patient risk factors." Because clinicians may see patients with medical risk factors with exacerbated health conditions due to delayed care, CMS proposes to increase the complex patient bonus to a maximum of 10 points in 2020. The agency acknowledges there is limited data available to assess whether this proposal is sufficient to mitigate those negatively impacted by caring for a complex patient population.

MGMA comment: MGMA supports the proposal to increase the complex patient bonus for the 2020 performance period. We encourage the agency to evaluate data that has come available since the time the rule was proposed to assess whether doubling the bonus is sufficient or whether an increase is warranted. Additionally, we encourage CMS to extend this policy through the 2021 performance period (2023 payment year) to account for continued challenges that result from delayed care or complexities arising from the pandemic. For example, the long-term health impacts of contracting coronavirus are currently unknown but are being evaluated. It is possible that patients who contracted the virus may see residual health effects, complicating treatment going forward. Further, the indirect impacts of the COVID-19 pandemic may create new challenges or exacerbate existing ones, such as the worsening or onset of mental health conditions, complexities arising from changes to socioeconomic status or loss of health insurance, and so forth. To account for these potential complexities, we urge CMS to address MIPS scoring policies at the outset. In addition to creating a hardship exception process as we recommended previously, addressing potential disparities or complications through increasing the complex patient bonus could offset potential negative impacts on clinicians caring for complex patients.

MIPS performance threshold

CMS proposal (85 Fed. Reg. 50316): CMS proposes to increase the MIPS performance threshold to

50 points in performance year 2021. The exceptional performance bonus threshold would be 85 points.

MGMA comment: MGMA strongly supports CMS' proposal to lower the previously finalized 2021 performance threshold of 60 points to 50 points due to the COVID-19 pandemic. While we appreciate CMS' proposal, we encourage CMS to consider maintaining the performance threshold at 45 points, which is the performance threshold in 2020.

Our member group practices report that they continue to divert energy and resources toward battling the COVID-19 pandemic and may not have the capacity to participate in data reporting in 2020. To support groups that will not be able to participate in 2020 MIPS but intend to resume participation in 2021, CMS must avoid increasing regulatory burden in 2021. We encourage the agency to reduce the MIPS performance threshold from 50 points as proposed to, *at most*, 45 points. Our rationale for recommending a threshold of 45 points is that this was the threshold for 2020; assuming there are at least some groups that will not report any data in 2020, maintaining the 2020 threshold for 2021 will accomplish CMS' intent of establishing a gradual increase in reporting obligations.

MGMA appreciates that since the inception of MIPS, CMS has taken an incremental approach to gradually ramping up MIPS participation requirements year-over-year. This includes gradually increasing the performance threshold in addition to category-specific policies, such as increasing quality measure data completeness requirements over time and instituting scoring floors. Some group practices will not be able to participate in the program for the 2020 performance year due to the COVID-19 public health emergency, which means they will be rejoining the program in 2021 (or later). Other groups may have been able to participate in some performance categories in 2020 or participate across all categories but to a lesser extent than they would have notwithstanding the pandemic. Assuming, *arguendo*, these groups are able to participate in MIPS for 2021, they will be subject to significantly more stringent reporting requirements than they encountered in 2019, the last year they were able to focus on MIPS reporting. To continue CMS' policy of gradually increasing MIPS reporting requirements each year, and in recognition of the disruptions caused by COVID-19 in 2020, we encourage the agency to extend the 2020 reporting threshold through the 2021 performance year.

Beginning in the sixth performance year (2022), MACRA requires CMS to set the performance threshold at the mean or median of final scores from a prior period. We understand that CMS' intent is to create a gradual transition by incrementally increasing performance thresholds until clinicians must meet requirements established in statute.

However, the public health emergency has caused significant disruptions, requiring policymakers to revisit certain policies. We believe that certain legislative changes are necessary to account for these disruptions in progress. Even if the public health emergency is behind us by 2022 and its residual effects have largely dissipated, the pandemic will inevitably disrupt the original timeline set forth by Congress to fully implement MACRA payment reforms. With this in mind, CMS may be afforded continued flexibility to set the MIPS performance threshold beyond the 2020 performance year, nullifying the requirement to move to a threshold set on past performance years. We encourage the agency to work with Congress on developing legislative fixes to ease this transition, and we stand ready to work with both the Administration and Congress on a strategy for how to best mitigate disruptions caused by COVID-19.

Advanced APMs

In the regulatory impact analysis of proposed policies, CMS estimates there will be between 196,000 and 252,000 qualifying participants (QPs) in Advanced APMs for 2021. This estimate assumes the

number of QPs will decrease in 2021 compared to 2020 figures, which estimated between 210,000 and 270,000 QPs for the 2020 performance year.[13]

MGMA recommends CMS expedite development of new APMs, particularly those that offer prospective, predictable payments. We also encourage the agency to include up-front financial support in these models. Prospective payments, such as capitation, can create a stable cash flow at a time when patient volume, and therefore fee-for-service revenue, is unpredictable.

QP threshold

CMS proposal (85 Fed. Reg. 50334): CMS proposes to revise its attribution methodology for prospectively attributed beneficiaries.

MGMA comment: We appreciate the proposal to update the methodology for calculating QP thresholds by excluding beneficiaries who are prospectively aligned to an APM Entity from the number of attribution-eligible beneficiaries for other APM Entities. The current methodology includes a beneficiary who is prospectively attributed to an APM Entity, and as a result, is precluded under model rules for one or more APMs from attribution to certain other APM Entities. This disadvantages APM Entities because their threshold score, or ratio of attributed to attribution-eligible beneficiaries, is lower due to reasons outside the control of its participants.

In addition, we have significant concerns over increases to QP thresholds that start in 2021 and urge CMS to consider how it can update its methodologies to avoid a situation where APM participants miss both QP threshold counts. CMS evaluates whether Advanced APM entities meet QP thresholds using a payment amount and patient count method. MACRA increases the QP *payment* threshold over time, and by 2021 sets the threshold at 75%. In contrast to the proscriptive approach for the payment threshold, MACRA permits CMS to make QP and partial QP determinations "using the same or similar percentage criteria (as specified in this subsection and such section, respectively), as the Secretary determines appropriate."[14]

MGMA appreciates that CMS has taken a more flexible approach to setting the patient count threshold and leveraged its secretarial discretion to set it lower than the statutorily prescribed payment counts. We respectfully request that CMS exercise its discretion to establish an even more flexible patient count threshold by maintaining the 2020 standard through 2021 and beyond. If CMS finds it does not have the authority to maintain 2020 levels going forward, we urge officials to work with Congress on implementing a statutory fix. MGMA stands ready to work with the agency on any and all efforts on this front.

APM entities have limited ability to increase payments or patients through the APM and thereby meet increased thresholds. Estimates have shown that more than one-third of MSSP ACOs, the largest APM program to date, that achieved QP status in 2019 are at risk of falling below QP thresholds in 2021.[15] To avoid backtracking on progress toward a value-based payment system, we encourage CMS to revisit its policy surrounding QP patient count thresholds.

APM payment

CMS proposal (85 Fed. Reg. 50332): CMS proposes to establish a hierarchy to determine where to transmit a QP payment; this would establish a sequential process for CMS to use when it cannot identify one or more TINs with which a QP has an affiliation. The agency also proposes to establish a "cutoff date", after which QPs could no longer contact the CMS helpdesk with reports of missing QP

[13] 84 Fed. Reg. 62548, 62946 (Nov. 15, 2019).
[14] Section 1833(z)(2)(D).
[15] Milliman white paper, Raise the Bar: How to Achieve QP Status During a Pandemic (July 2020).

payments. The cutoff date would be Nov. 1 of each payment year, or 60 days from the day on which the initial round of APM incentive payments is made (whichever is later), after which CMS will no longer accept helpdesk requests from QPs who have not received payments.

MGMA comment: While we appreciate efforts by the agency to more quickly and efficiently distribute QP bonuses, we do not agree with the proposal to establish a cutoff date for contacting the CMS helpesk for outstanding payments. We also understand the agency has encountered difficulties when disbursing APM incentive payments for certain QPs, such as those who are no longer affiliated with the group through which they participated in the Advanced APM and became eligible for the 5% incentive payment. However, we do not believe that a cut off date of 60 days following the initial round of APM bonus payments or Nov. 1 is a fair policy. The process for disseminating APM bonuses during the inaugural year, 2019, was not very transparent, and it was not clear from our conversations with CMS or our membership why some groups received payments before others. In order for us to evaluate whether 60 days following the first APM bonus distribution is appropriate, we would need more data or information on the process CMS uses, as well as data on distributions to date, e.g., the 2019 and 2020 payment years. Until this information can be made available, we oppose establishing a "cutoff date" to avoid situations wherein group practices are forced to relinquish their right to a payment bonus earned two years prior due to administrative complexities, inadvertently missing arbitrary deadlines, or other legitimate reasons. It is not necessarily clear the exact date that CMS has begun transmitting bonuses to APMs based on past year experience, making it impossible for group practices to understand when the 60-day deadline begins tolling. While we hope that most groups would receive their QP payments in a timely manner and therefore would not have a need to contact the helpdesk for missing payments, we are only in the second payment year for APM bonuses. Therefore, it is impossible to assess how often this deadline would be applicable or whether it is appropriate.

APM targeted review

CMS proposal (85 Fed. Reg. 50334): Beginning with the 2021 QP performance period, CMS proposes to create a targeted review process for cases in which an eligible clinician or APM entity believes CMS made a clerical error such that an eligible clinician was not included on a Participation List of an APM entity participating in an Advanced APM for the purposes of QP or Partial QP determinations.

MGMA comment: MGMA strongly supports this proposal and encourages CMS to adopt a process whereby Advanced APM QPs or entities can submit a request for CMS to conduct a review of Participation Lists and/or QP calculations for potential errors. Following the inaugural QPP performance year, MGMA members reported instances where individuals were inadvertently left off Participation Lists, often through no fault of the practice or individual involved, which resulted in qualified Advanced APM participants not receiving appropriately earned incentives for their participation in an Advanced APM.

Conclusion

We appreciate the opportunity to share our comments regarding the proposed changes to the Medicare PFS and QPP and to offer recommendations to improve and simplify these policies to support group practices as they care for patients. Should you have any questions, please contact Mollie Gelburd at mgelburd@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg, MGA

Senior Vice President, Government Affairs