



September 6, 2022

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

Re: Medicare and Medicaid Programs: Calendar Year 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Medicare Shared Savings Program Requirements, etc. [CMS-1770 -P]

Dear Administrator Brooks-LaSure:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the calendar year (CY) 2023 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule, published in the *Federal Register* on July 29, 2022.

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

Key Recommendations

MGMA appreciates the Centers for Medicare & Medicaid Services' (CMS') leadership in improving Medicare and respectfully offers the following comments in response to the CY 2023 PFS proposed rule. In summary, we encourage the agency to:

- **Urge Congress to provide a positive update to the Medicare conversion factor in CY 2023 and all future years.** MGMA is deeply concerned with the estimated reduction to the CY 2023 conversion factor and its potential impact on medical group practices. The cuts stemming from the 4.42% decrease in the CY 2023 conversion factor paired with the potential impact of Statutory Pay-As-You Go (PAYGO) are simply unsustainable. In an MGMA poll conducted on August 30, 2022, 90% of medical practices report that the projected reduction to 2023 Medicare payment will reduce access to care.¹

¹ MGMA Stat, August 30, 2022. <https://www.mgma.com/data/data-stories/patients-and-practices-face-dire-consequences-of-p>

- **Move forward with implementing improvements to other E/M services on Jan. 1, 2023, 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.
- **Finalize the proposal to align telehealth services with the Consolidations Appropriations Act, 2022 (CAA, 2022) and continue to allow certain telehealth services to remain on the Medicare Telehealth Services List for 151 days after the expiration of the PHE, as well as permanently continue to cover and pay for audio-only visits permanently.**
- **Redefine “substantial portion” for purposes of split (or shared) E/M services to better reflect the team-based approach to care utilized by practices.** MGMA appreciates the additional flexibility to permit practices to bill for split (or shared) E/M visits based on medical decision making or time, however, MGMA encourages CMS to continue partnering with stakeholders to create a permanent solution to split (or shared) E/M billing.
- **Avert projected payment cuts to clinical diagnostic laboratory testing (CDLT).** MGMA has long expressed concerns with the flawed data collection and reporting process used to reduce CDLT payment rates. MGMA reiterates our concerns about the impact of these reductions on CDLTs that will force physician office laboratories to cease providing testing in office and reduce patient access.
- **Finalize the proposed policy to create the Advanced Incentive Payment (AIP) pathway within the Medicare Shared Savings Program (MSSP), with modifications.** MGMA believes that all practices should have an accessible pathway to participate in a value-based payment model. The proposed AIP will create additional support for smaller and more rural practices, that furnish care to historically underrepresented patient populations, to participate in MSSP.
- **Create additional flexibilities for practices interested in taking on risk within MSSP by finalizing the proposal to establish a glidepath to risk.** Many practices have not participated in MSSP due to the accelerated timeline that requires an accountable care organization (ACO) to bear financial risk for the assigned patient population. MGMA supports CMS’ proposal to create a longer onramp for ACOs to familiarize themselves in a one-sided risk arrangement before transitioning to a two-sided financial model.
- **Maintain the higher COVID-19 vaccination administration payment rate for at least two years beyond the end of the declared public health emergency (PHE).** Staffing shortages, need for additional patient education, and supply and storage concerns with COVID-19 vaccines necessitate a higher payment rate beyond the Jan. 1 following the declared end of the PHE.
- **Finalize the proposal to change the mandatory Electronic Prescribing for Controlled Substances (EPCS) compliance date for sending letters to noncompliant prescribers from Jan. 1, 2023, to Jan. 1, 2024, and provide assistance and flexibility when assessing penalties for noncompliance.** MGMA appreciates the additional time this will afford providers to implement new technologies necessary to comply with this mandate.
- **Apply the Automatic Extreme and Uncontrollable Circumstances (EUC) policy to individual eligible clinicians under the Merit-based Incentive Payment System (MIPS) for the 2022 performance year.** MGMA urges CMS to apply the automatic EUC policy in 2022 to continue providing practices with critical administrative relief. Throughout the performance year,

practices have faced increased staffing shortages and should not prioritize measure reporting at the expense of delivering care to patients. Additionally, providing practices with this flexibility will prevent significant future payment cuts as practices simultaneously face major projected cuts across the Medicare program.

- **Adjust subgroup reporting requirements under the MIPS Value Pathways (MVP) reporting option to better reflect practices' team-based approaches to care and alleviate unnecessary additional administrative hurdles.** MGMA has long advocated against requiring practices to form subgroups for quality reporting activities. Practices leverage every member of the clinical team to support effective and patient-centered care. Quality reporting should support the team-based approach to care and not undermine it.

Ongoing COVID-19 Pandemic Impact

In effect since January 2020, the COVID-19 public health emergency (PHE) continues to have an ongoing impact on medical group practices across the country. During the height of the pandemic, practices were required to quickly shift entire care delivery models from in-person to virtual and adapt to provide patients with the highest quality of care, while continuing to respond to pandemic relief efforts. While transmission rates have declined, the COVID-19 pandemic continues to have a resounding impact on group practices, from critical capacity issues to ongoing staffing shortages. Group practices are continuing to struggle to return to the “new normal.”

Staffing was the top concern for 73% of medical group practices heading into CY 2022.² Staffing shortages, compounded by inflation and other financial pressures, threaten an already thinly spread healthcare workforce. A February 2022 MGMA poll similarly revealed that 41% of practices saw increased turnover rates in the last quarter of CY 2021.³ Staffing constraints have only worsened as the healthcare community continues to struggle to rebound after the height of the pandemic.

With staffing shortages and an increase in the demand for care, practices are struggling to ensure patients receive timely and appropriate care. In CY 2022, 61% of group practices had to reduce the number of services provided due to staffing shortages.⁴ Medical group practices have described the critical capacity many are operating under, with patients having to wait weeks or months to receive preventive care and patients lining the halls of emergency departments waiting for available beds.

Staffing shortages jeopardize patient outcomes and increase costs for practices and waste for the healthcare system. Looking ahead to Medicare payment policies in CY 2023, each proposed policy must be considered in the context of the current state of the healthcare system; one in which practices do not have excess time, staff, or resources to devote to administratively burdensome tasks that neither add value nor improve the quality of care provided to patients.

Physician Fee Schedule

Changes in Relative Value Unit (RVU) Impacts

² MGMA Stat, September 21, 2021. <https://www.mgma.com/data/data-stories/staffing,-uncertainty-among-top-pandemic-challenge>

³ MGMA Stat, February 2, 2022. <https://www.mgma.com/data/data-stories/as-compensation-competition-continues,-medical-gro>

⁴ MGMA Medicare Financial resiliency Member Questionnaire, June 2022.

CMS proposal (87 Fed. Reg. 46385): Due to statutory budget neutrality requirements, CMS estimates the CY 2023 physician conversion factor will be 33.0775, which is approximately 4.42% lower than the CY 2022 conversion factor of 34.6062.

MGMA comment: MGMA recognizes that CMS is constrained by statutory budget neutrality requirements, however, we remain deeply concerned about the estimated reductions to the conversion factor in CY 2023. The 4.42% decrease to the conversion factor, paired with the effects of Statutory PAYGO will result in devastating cuts to Medicare reimbursement for CY 2023. MGMA asks that CMS urge Congress to provide a positive update to the Medicare conversion factor in CY 2023 and all future years.

In a member survey of over 500 medical group practices across 45 states and representing all specialties and sizes of practices, 92% of respondents stated that already in CY 2022, Medicare reimbursement rates do not adequately cover the cost of care provided to beneficiaries.⁵ A 4.42% reduction to the conversion factor, compounded by a 4% PAYGO sequester, will have detrimental effects on the delivery of care and patient access to medically necessary services in CY 2023. Surveyed medical groups indicated they are considering a number of business decisions as a result of projected payment cuts, including:

- **58%** are considering **limiting the number of new Medicare patients**
- **58%** are considering **reducing the number of clinical staff**
- **29%** are considering **closing satellite locations**
- **77%** are considering **delaying the purchase of new clinical equipment**

MGMA is deeply concerned the proposed payment reductions will have a detrimental impact on access to care for Medicare beneficiaries and financial sustainability for medical group practices. MGMA's member survey revealed trends across states and geographic regions that will significantly disrupt patient access to care, practice operations, and overall investment throughout the healthcare industry. The top five identified trends as a result of the payment cuts include:

1. Reducing or eliminating the number of Medicare beneficiaries served;
2. Projected delays in scheduling care, resulting in up to 6 months' wait for services;
3. Decreased ability to recruit staff at all levels, including physicians, clinical support staff, and administrative staff, especially in rural areas;
4. Reduced participation in value-based payment contracts as limited resources and revenue are diverted away from non-essential practice activities; and
5. Closing satellite offices or selling the practice due to insufficient revenue streams.

Telehealth

Requests to Add Services to the Medicare Telehealth Services List for CY 2023

CMS proposal (87 Fed. Reg. 45886): CMS proposes adding additional services to the Medicare Telehealth Services List on a Category 3 basis through the end of CY 2023.

MGMA comment: MGMA appreciates the steps CMS took to expand services on a Category 3 basis and supports CMS adding additional services through the end of CY 2023. Many of our member groups continue to offer telehealth to their patients, and these services continue to serve as a lifeline for patients

⁵ MGMA Medicare Financial resiliency Member Questionnaire, June 2022.

who do not have access to in-person care. Telehealth services can make visits more efficient, available, and affordable for those traveling long distances. However, as discussed in MGMA's CY 2021 and CY 2022 PFS proposed rule comments, we recommend that these services be made permanent.

Medical group practices have invested in technology, additional resources, and modified workflows to operationalize telehealth visits. Instead of eliminating services after a predetermined or prescriptive date, CMS should permanently add them and let clinicians decide when they believe it is clinically appropriate to furnish such services virtually.

CMS could permanently add Category 3 services, monitor, and collect information on their utilization impacting program/patient cost and clinical efficacy throughout the PHE. MGMA believes it is critical to collect and analyze this data outside of the PHE to get a more comprehensive understanding of how these services are utilized via telehealth. Without knowing exactly when the PHE will end, we suggest permanently adding these services to the telehealth list and propose potentially removing certain services through formal rulemaking when an appropriate amount of time has passed to collect the necessary data.

Implementation of Telehealth Provisions of the Consolidation Appropriations Acts, 2021 and 2022

CMS proposal (87 Fed. Reg. 45887): To align with the CAA, 2022, CMS is proposing to continue allowing certain telehealth services that would otherwise not be available via telehealth after the expiration of the PHE to remain on the Medicare Telehealth Services List for 151 days after the expiration of the PHE. CMS proposes to codify several of these provisions, including delaying in-person requirements for mental health services until 152 days after the expiration of the PHE, extending originating site/geographic restriction flexibilities, allowing temporary payment policies for rural health clinics and federally qualified health centers, expanding the list of eligible telehealth providers to include qualified occupational therapists, qualified physical therapists, qualified speech-language pathologists, and qualified audiologists, and providing payment for certain services furnished via audio-only technology.

MGMA comment: MGMA supports this proposal, which is in alignment with the requirements of the CAA, 2022. Throughout the pandemic, physician practices have expressed confusion regarding the status of telehealth waivers and the effect the conclusion of the PHE will have on these waivers. If CMS were to propose anything out of alignment with the CAA 2022, it would result in extreme confusion and disruption.

MGMA urges CMS to continue to cover and pay for audio-only services permanently. Throughout the COVID-19 PHE, MGMA has received feedback from group practices on the value of audio-only visits. In an August 2022 poll conducted by MGMA, 78% of respondents reported that their Medicare patients would benefit from have the option of audio-only visits when clinically appropriate outside of the PHE.⁶ These visits serve as a lifeline for patients who do not have access to broadband and/or do not have the necessary equipment to facilitate a audio-visual visit. MGMA asserts that CMS has the regulatory authority to reimburse these visits and urges the agency to do so following the 151-day extension afforded by the CAA, 2022.

CMS proposal (87 Fed. Reg. 45899): CMS proposes that Medicare telehealth services furnished on or before the 151st day after the end of the PHE, in alignment with the extensions of telehealth-related flexibilities in the CAA, 2022, will continue to be processed for payment as Medicare telehealth claims when accompanied with the modifier "95."

⁶ MGMA poll, Physician Fee Schedule Q&A, Aug. 23, 2022.

CMS proposes to align those telehealth services described as taking place in the beneficiary’s home, using POS “10” for Medicare telehealth, and those services not provided in a patient’s home, using POS “02” for Medicare telehealth, to be made at the same facility payment amount. CMS believes that the facility payment amount best reflects the practice expenses, both direct and indirect, involved in furnishing services via telehealth.

MGMA comment: MGMA believes reverting back to the original and typically lower facility rate would not reflect the true cost of delivering these services. We urge CMS to support appropriate reimbursement for these services beyond the 151st day after the end of the PHE.

Outside of the COVID-19 PHE, telehealth visits are reimbursed at the “facility rate” in Medicare, which represents a significant reduction in practice expense payments for overhead costs. MGMA has heard from member practices that the cost and administrative burden of providing care to patients is not significantly reduced when care is furnished via telehealth. Practices still need to schedule telehealth visits, facilitate calls, virtually check-in patients, document visits, and create follow-up appointments with patients. There could also be the added expense of HIPAA compliant IT infrastructure costs and technical issues during and after the visit that could require troubleshooting on the part of the practice, which takes up additional staff time. Reimbursement must be adequately high enough to cover the cost of delivering high quality care.

Practices have struggled to establish multiple workflows to accommodate both virtual and in-person visits. For telehealth to be a viable option following the conclusion of the PHE, reimbursement should account for the many factors and costs that are involved in facilitating a telehealth visit. MGMA urges CMS to consider reimbursing these visits at rates that more closely align with the resources required to furnish them.

E/M Services

Other E/M Visits

CMS proposal (87 Fed. Reg. 45987): CMS proposes new coding structure and valuations to update the inpatient and observation visits, emergency department visits, nursing facility visits, domiciliary or rest home visits, home visits, and cognitive impairment assessment codes (or “Other E/M”).

MGMA comment: MGMA 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 the Other E/M services starting Jan. 1, 2023. 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. We urge the Department of Health and Human Services (HHS) and CMS to use any and all authority available to not apply PFS budget neutrality in CY 2023.

Split (or Shared) E/M Visits

CMS proposal (87 Fed. Reg. 46002): CMS proposes to extend the additional flexibilities introduced in the CY 2022 final Medicare Physician Fee Schedule ([86 Fed. Reg. 64996](#)) related to the definition of “substantive portion” in terms of split (or shared) E/M billing. In CY 2022, substantive portion is defined as either history, exam, medical decision making, or more than half of total time. CMS proposes to extend this definition through CY 2023 to provide additional transition time for billing split (or shared) visits.

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

Across practices and among providers there is significant variability in the time it takes to perform a service. As there is no standardization within a practice among the clinicians, this would create significant billing differences depending on what combination of physician and non-physician practitioners (NPPs) are furnishing the service. MGMA and our member group practices champion team-based approaches to care. We have concerns that this policy, as introduced in CY 2022 and as proposed in this rulemaking cycle, will undermine collaborative care among physicians and NPPs.

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

In March 2022, MGMA and other leading healthcare associations sent a [letter](#) to CMS highlighting collective concerns about the split (or shared) billing policy. MGMA strongly recommends CMS update the split (or shared) E/M policy to define “substantive portion” by either MDM or more than half of total time.

Rebasing and Revising the Medicare Economic Index (MEI)

CMS proposal (87 Fed. Reg. 46041): CMS proposes to update the MEI weights using 2017 data from the United States Census Bureau’s Service Annual Survey (SAS). However, the agency clarifies that they will not implement these new weights in CY 2023 as they must first seek additional comments due to significant redistribution.

MGMA comment: The MEI, first implemented in 1975, has long served as a measure of practice cost inflation and a mechanism to determine the proportion of payments attributed to physician earnings and practices costs. The MEI measures changes in the prices of resources used in medical practices including, for example, labor (both physician and non-physician), office space and medical supplies. These resources are grouped into cost categories and each cost category is assigned a weight (indicating the relative importance of that category) and a price proxy (or proxies) that CMS uses to measure changes in the price of the resources over time. The MEI also includes an adjustment to account for improvements in the productivity of practices over time.

From 1975, when payments reflected the usual, customary and reasonable charge payment methodology, through 1993, the year after implementation of the Resource Based Relative Value Scale (RBRVS), the physician earning component was 60% and the practice expense component, including professional liability insurance (PLI) costs, was 40%. These initial weights were derived from data obtained from the AMA. In the nearly 50 years since the initial establishment of the MEI, data collected by the AMA has served as the consistent source of information about physicians’ earnings and their practice costs.

In 1993, the MEI components were updated, using AMA data and then proportioned to 54.2% Physician Work, 41% Practice Expense and 4.8% PLI. Currently, the allocation is 50.9% Physician Work, 44.8% Practice Expense and 4.3% PLI. The CMS proposal is to dramatically shift payment allocation away from physician earnings (work) to practice expense: 47.3% Physician Work, 51.3% Practice Expense and 1.4% PLI using non-AMA data.

MEI History

	1975-1992	1993	Current	Proposed
Physician Work	60%	54.2%	50.9%	47.3%
Practice Expense	40%	41.0%	44.8%	51.3%
Professional Liability Insurance	(incl with PE)	4.8%	4.3%	1.4%

The current MEI weights are based on data obtained from the AMA’s Physician Practice Information (PPI) Survey. This survey was last conducted in 2007/2008 and collected 2006 data. However, the AMA is actively engaged in a process to collect these data again.

The proposed MEI updates would result in significant specialty redistribution and geographic redistribution as CMS proposes to modify weights of the expense categories (employee compensation, office rent, purchased services and equipment/supplies/other) within the practice expense Geographic Practice Cost Index (GPCI). A significant reduction in the weight of office rent from 10.2% to 5.9% would lead to reductions in the payment to urban localities and increases to payment in rural areas and states with a single GPCI. CMS’s impact analysis should also be expanded to consider how significant decreases in PLI payment may negatively impact geographical areas with relatively high PLI premiums.

The changes in the MEI that CMS is proposing are almost entirely related to the category weights. A change in the price proxy is recommended for just one of the cost categories which accounts for only 2% of the index. CMS is not proposing a change to the productivity adjustment. The proposed changes in the category weights are primarily derived from the Census Bureau’s 2017 SAS for the “Offices of Physicians” industry, which was not designed with the purpose of updating the MEI. As a result, there are key areas (physician work, nonphysician compensation and medical supplies) where CMS must use data from other sources to work around this important gap.

Several of the flaws in utilizing the SAS data for this purpose, include:

- Seven percent of the revenue for “Offices of Physicians” on the 2017 SAS was from non-patient care sources (e.g., grants, investment income) and any expenses associated with these sources cannot be excluded.
- The SAS for “Offices of Physicians” collects payroll and benefits for all staff combined but the MEI has separate cost categories for physician and non-physician compensation. Non-physician compensation is further broken out in the MEI by staff type. CMS is proposing to use the Bureau of Labor Statistics’ (BLS) 2017 Occupational Employment and Wage Statistics (OEWS) data to estimate the share of SAS personnel costs that apply to physicians (including qualified health care professionals (QHPs)) and non-physicians. Based on the 2017 OEWS, CMS states that 63.2% of employee compensation for “Offices of Physicians” is for physicians and QHPs. CMS appears to have misclassified registered nurse salaries in this estimate. Additionally, the OEWS only covers employees, so it is missing compensation for a large segment of the physician population (practice owners). To compensate, CMS is proposing to estimate total compensation for practice owners as a share of practice net income from the 2017

SAS (the difference between total revenue and total expense which amounted to \$44.9 billion out of \$490.9 billion in revenue for 2017). The share of net income proposed is the estimated percent of patient care physicians that are owners (46.5%), averaged from the 2016 and 2018 AMA Physician Practice Benchmark Surveys, resulting in an estimated \$20.9 billion in compensation for owners. **CMS’s estimate of \$20.9 billion in compensation for owners represents just 10% of total compensation for all physicians and QHPs (\$203.8 billion), which is far out of line with any reasonable estimate since nearly half of physicians in the United States are owners.**

- CMS used BLS data to split out the US Census SAS data using the NAICS 6211 “Offices of Physicians” category. However, only 64% of employed physicians are in this category in both the US Census SAS and BLS OEWS datasets. This analysis excludes 36% of physicians who are employed in other health care settings, such as hospitals. For example, the NAICS 6221 “General Medical and Surgical Hospitals” category was not included in CMS’ analysis and this category includes 158,880 employed physicians according to the 2017 BLS OEWS data. Hospital-based physicians have a higher proportion of physician earnings and PLI cost relative to other practice costs, as many of these other costs are the responsibility of the hospital or other facility. The CMS proposal greatly underrepresents the cost share of physician work and PLI relative to practice expense due to this inappropriate exclusion.
- In the current MEI, CMS excludes expenses for separately billable supplies and drugs. The 2017 SAS for “Offices of Physicians” has a single category for Medical Supplies without any breakout for the separately billable component. To estimate separately billable supply and drug expense, CMS proposes to age forward AMA-PPI results for these expenses and then compare the estimated total to Medical Supplies expense from the SAS (finding that 80% of Medical Supplies expense is for separately billable medical supplies or drugs). There are two problems with the CMS proposed approach: 1) The measures used to age expenses forward are not entirely appropriate (using growth in Medicare Part B drug spending when an all-payer measure would be better, and using measures of inflation (CPI and PPI from BLS) to age spending); and 2) totals estimated from two entirely different surveys are being compared when those surveys may have different populations and methods (for example, the wording of the questions and direction on what to include in the category could be entirely different).

The dramatic decrease in the weight for PLI cost seems unrealistic. In CY 2021, the Medicare physician payment schedule allowed charges were \$91 billion. If PLI payment only represented 1.4% of this payment, total Medicare spending on its share of these premiums and self-insured actuarial costs would be \$1.274 billion. With more than one million physicians and other health care professionals billing Medicare, this would compute to Medicare paying an average of \$1,275 per individual. Assuming Medicare represents approximately 25% of physician payment, an understated \$5,100 in PLI premium cost results. This is in direct contradiction to the volume weighted PLI premium costs of \$21,700 computed by CMS elsewhere in the Proposed Rule. It appears that a 4-5% PLI weight is more appropriate than the proposed 1.4%.

Clinical Laboratory Fee Schedule (CLFS)

CMS proposal (87 Fed. Reg. 46070): CMS proposes confirmatory language with statute to reflect additional delays in the reporting and payment reduction periods for clinical diagnostic laboratory tests (CDLTs). Previous legislation (P.L. 116-94 and P.L. 116-136) revised and delayed the data reporting periods and payment reductions for CDLT under the CLFS. The most recent legislation, the Protecting Medicare and American Farmers from Sequester Cuts Act (P.L. 117-71), delayed CDLT data reporting

until Jan. 1, 2023, implementing the three-year reporting cycle every three years thereafter. Under current law, the CY 2023 reporting period will be based on data collected during Jan. 1, 2019, and June 30, 2019.

MGMA comment: Laboratory testing furnished at the point-of-care, such as in a physician's office, enhances patient-centered care and outcomes while also decreasing the costs of care coordination and administrative processes in the healthcare system. MGMA recommends CMS use its authority to avert the significant reduction in payment for critical healthcare tests to maintain patient access to medically necessary diagnostic testing.

MGMA has long expressed concerns with the flawed data collection and reporting process used to reduce CDLT payment rates. MGMA reiterates our concerns about the impact of these reductions on CDLTs that will force physician office laboratories (POL) to cease providing testing in office, reducing patient access to testing.

POLs have played a critical role in responding to the COVID-19 pandemic, and like elsewhere in the healthcare system, appropriate and effective testing is impacted by the current staffing crisis. Introducing a 15% reduction in payment for CDLTs will significantly impact the ability of practices to ensure patients receive the most appropriate and necessary testing, especially in rural areas where a POL may be the only testing facility near a patient. MGMA is concerned with the impact these cuts will have on access to testing in rural and underserved areas.

Delayed or abandoned testing may result in more advanced diseases and diagnosing, impacting patient outcomes, and increasing costs across the healthcare system. Improving payment for diagnostic testing will support efforts to reduce waste throughout the healthcare system. Patients with chronic conditions, such as diabetes, heart disease, and common cancers, rely on routine testing to avoid costly interventions.

Expansion of Coverage for Colorectal Cancer (CRC) Screening

CMS proposal (87 Fed. Reg. 46081): CMS proposes to expand coverage for certain CRC screening tests to include follow-up screening colonoscopy after a Medicare covered non-invasive stool-based CRC screening test. The agency also proposes to lower the age of coverage from 50 to 45 years consistent with recommendations from the United States Preventive Services Task Force (USPSTF).

MGMA comment: MGMA appreciates the ongoing support for expanded access to colon screening testing. During the pandemic, many individuals forwent preventive screening services, such as receiving appropriate screening for CRC. We are pleased the agency is continuing to expand coverage to vulnerable populations for the early detection of CRC, especially as African Americans are 20% more likely to develop CRC and 40% more likely to die from the disease compared to other racial/ethnic groups in the U.S.⁷ The proposed expansion for coverage is an important step to support shared goals to address healthcare inequities in healthcare.

Medicare Shared Savings Program (MSSP)

Advanced Incentive Payments (AIPs): Eligibility

⁷ [Colorectal Cancer Rates Higher in African Americans, Rising in Younger People](#). American Cancer Society, September 3, 2020.

CMS proposal (87 Fed. Reg. 46099): CMS is proposing to create a new upfront payment process based on previously tested models under the CMS Innovation Center to support new entrant ACOs furnishing care to underserved populations. In order to meet eligibility requirements to qualify for application to receive AIPs, CMS proposes an ACO must meet certain criteria:

1. The ACO is not a renewing or re-entering ACO;
2. The ACO has applied to participate in MSSP under any level of the BASIC track glide path and is eligible to participate in MSSP;
3. The ACO is inexperienced with performance-based risk Medicare ACO initiatives; and
4. The ACO is a low revenue ACO.

MGMA comment: MGMA applauds CMS for continuing to provide additional support for new entrant ACOs interested in participating in MSSP, particularly for those providing care to underserved populations. Historically, participation in value-based payment arrangements have disproportionately left out minorities and rural communities. We agree with the agency that it is important that these smaller, physician-led organizations that provide critical care to these populations have the financial support to participate in MSSP and that the AIPs provide critical financial support to cover some of the start-up costs for these ACOs.

CMS defines a “low revenue” ACO as one whose total Medicare Parts A and B fee-for-service (FFS) revenue from assigned participants over the past 12 months is less than 35 percent of the total Medicare Parts A and B FFS expenditures for the assigned beneficiaries. MGMA is concerned that establishing this threshold will limit the ability of new entrant ACOs that would benefit from receiving AIPs from applying to the program. While recognizing the intent to limit the availability of AIPs to those ACOs that would most benefit from receiving the up-front funding, we believe that the other criteria will ensure that larger ACOs with significant experience under value-based payment arrangements in Medicare will not be eligible. Further, it is important that all new-entrant ACOs interested in participating in the program have access to this advanced payment pathway to support participation in MSSP as a mechanism to help address health equity and expand the Medicare beneficiary population served by enrolled providers.

MGMA is encouraged that CMS continues to incorporate lessons learned from Innovation Center models into the permanent MSSP. Stability for practices is critical in value-based care initiatives. MGMA recommends CMS continue to critically evaluate the performance of models tested through the Innovation Center to create additional permanent participation options within the Medicare program, within MSSP or as a standalone permanent model. We believe this will not only bolster participation in value-based payment arrangements, but will also support higher quality of care furnished to Medicare beneficiaries.

Advanced Incentive Payments (AIPs): Application and Timeline

CMS proposal (87 Fed. Reg. 46100): CMS proposes that the application for funding through the AIP will be incorporated into the MSSP application process.

MGMA comment: MGMA supports the proposal to incorporate the AIP application process into the established MSSP application period. We would urge CMS to provide clear and consistent communication with practices and ACOs both informing them of the upcoming opportunity to apply for advanced funding, as well as detailed instructions about the application process.

While MGMA maintains that the low revenue eligibility requirement may be unnecessary to support the AIP program, if finalized as a component of the program, we appreciate the proposal to provide ACOs with a preliminary determination related to low revenue status. We believe this will support higher

participation in the AIP and among new entrant ACOs and encourage higher participation in value-based payment arrangements.

MGMA recommends CMS permit new entrant ACOs that applied to participate in MSSP in CY 2023 to apply to receive AIP payments in 2024. While these ACOs will have had a year of experience under MSSP prior to the distribution of these funds, MGMA maintains that it is critical to ensure there are no incentives created that encourage the delayed participation in MSSP. A transitional policy that permits CY 2023 new entrant ACOs to apply for the AIP in 2024 aligns with CMS' stated goals to support increased and robust participation among new entrant ACOs in MSSP and prevent eligible ACOs from delaying participation in MSSP until 2024.

Advanced Incentive Payments (AIPs): Use and Reporting of Funds

CMS proposal (87 Fed. Reg. 46101): CMS proposes the funds must be used to support ACO participation and quality improvement activities across three broad categories:

1. Increased staffing,
2. Social determinants of health (SDOH) strategies, and
3. Health care provider infrastructure.

MGMA comment: While we agree that the proposed categories for using AIP funding appropriately capture the critical infrastructure required to begin participating in MSSP, MGMA requests CMS provide additional clarification on the use of AIP funding for bonuses for purposes of increasing staffing and supporting retention. As CMS is aware, staffing continues to be a top issue for many practices. This use of funding will likely be used to support increased staffing needs to meet the demands of successfully participating in a value-based payment arrangement. While CMS does include "increased staffing" as an appropriate use of the funds, MGMA recommends CMS provide clear language that states the AIP funding can be used to provide appropriate bonuses to staff in order to support retention. MGMA strongly supports preventing funds from increasing bonuses for high-earning executives, however, we believe that the AIP will be critical in retaining staff, both clinical and administrative, to support participation in a new entrant ACO.

CMS states that bonuses may be provided with these funds if tied to successful implementation of SDOH screenings or care management guidelines or used to retain clinical staff serving underserved populations. However, MGMA does not believe this narrow exception provides sufficient flexibility for practices to retain critical staff essential to successful participation in MSSP. For example, administrative staff responsible for coordination activities, quality reporting, and practice improvement, are just as critical to ensuring successful investment in value-based initiatives and continued participation. Further, MGMA believes that the selection criteria used to determine eligibility for the AIP program will sufficiently ensure that AIP funding does not support ACOs that do not need the funding to create the infrastructure needed to participate in a value-based payment arrangement.

CMS proposal (87 Fed. Reg. 46103): CMS proposes the funds will be distributed in a one-time \$250,000 payment and eight quarterly payments based on assigned beneficiaries and associated patient risk-factor scoring, capped at 10,000 beneficiaries.

MGMA comment: Based on MGMA member feedback, the proposed \$250,000 one-time amount will insufficiently cover start-up costs for most, if not all, new entrant ACOs. MGMA recommends CMS increase the one-time funding amount distributed via the AIP and permit ACOs to request an amount that they believe will cover the initial costs and support the creation of the ACO and the infrastructure needed to participate in MSSP.

MGMA disagrees with the CMS statement that “initial ACO start-up costs do not vary significantly by the size of an ACO or by the underlying level of risk of an assigned beneficiary population.” The intent of the AIP program is to support new entrant ACOs in establishing the infrastructure and population health management processes essential to successfully participate in MSSP. While all eligible ACOs will be new entrants into value-based payment arrangements within the Medicare program, they will likely vary in experience with value-based contracts with commercial payers and with Medicare Advantage contracts. With less experience, ACOs will require increased funding to support the technical infrastructure, the staffing requirements, or the care coordination activities in which the ACO will invest to participate in the MSSP.

Advanced Incentive Payments (AIPs): Recoupment of Advanced Payment

CMS proposal (87 Fed. Reg. 46109): CMS proposes to recoup the advanced payments distributed to the ACO from any shared savings earned by the ACO.

MGMA comment: MGMA recommends CMS delay the recoupment of funds over a longer time period as we believe that immediate recoupment will disadvantage these new entrant ACOs. For example, we would urge CMS to consider a percent recoupment per agreement period from shared savings. MGMA is concerned that recouping all savings will financially disadvantage certain ACOs participating, especially ACOs that are serving lower income and underserved populations. Savings are used to reinvest in the participating ACO, if an ACO that performs well on quality metrics and achieves in savings under the agreement. The ACO should not be penalized and have all the shared savings recouped due to the need for an advanced payment to support participation. We believe this will undermine the success of the program and these ACOs.

Glidepath to Risk

CMS proposal (87 Fed. Reg. 46114): CMS proposes that for agreement periods beginning Jan. 1, 2024, eligible ACOs can participate in a 5-year agreement period under a one-sided model. Under this proposal, CMS would permit an eligible ACO to participate under a one-sided risk model for an entire 5-year agreement period and then begin the glidepath to risk-bearing in the second agreement period, for a total of 7 years in a one-sided risk model.

MGMA comment: MGMA supports this proposal from the agency to create additional pathways for certain ACOs inexperienced with risk-bearing arrangements. In recent years, there has been a stagnation of new entrant participants applying to participate in MSSP. We believe that this proposal, in coordination with other proposed policies in this year’s rulemaking cycle will greatly support our shared goals to advance value-based care initiatives.

We agree with CMS that every ACO is different and has a different path to risk-bearing if that is the ultimate goal for the participating practices. Providing this additional flexibility will ensure that each practice has the opportunity to participate in MSSP.

Beneficiary Assignment

CMS proposal (87 Fed. Reg. 46122): CMS proposes to expand the definition used to identify primary care services used to assign beneficiaries to ACOs to include additional codes, including:

- Add HCPCS codes for prolonged nursing facility services (GXXX2) and prolonged home services (GXXX3).
- Add HCPCS codes for chronic pain management (CPM) (GYYY1 and GYYY2).

- Remove the reference to “place of service modifier 12” from the description for E/M home services (CPT codes 99341 through 99350) to reflect changes to the guidelines that expand the codes to include services provided in places of service other than a private residence.

MGMA comment: MGMA supports the proposed revisions to the definition of primary care services for purposes of ACO beneficiary assignment and urges CMS to finalize the policy as proposed.

However, MGMA does encourage CMS update its quality performance standard policy and not tie ACO quality performance to all MIPS clinician quality performance scores. We do not believe that this policy accurately evaluates quality performance across programs and inequitably penalizes ACOs. Further, this policy does not permit ACOs to know the quality performance standard target until after the performance period and data reporting closes, yet significantly impacts whether and how much an ACO shares in savings. An ACO that performs well in comparison to other ACOs reporting the same measures, may not perform well in comparison to MIPS clinicians. MGMA urges CMS update this policy to align with other policies within MSSP that support greater and robust participation in value-based payment arrangements.

Quality Performance Standard and Reporting

CMS proposal (87 Fed. Reg. 46127): CMS proposes to update the quality reporting standard beginning in the 2023 performance year to reflect a sliding scale approach to quality performance used in determining an ACOs amount of shared savings. If an ACO achieves a quality performance score equal to the at least the 10th percentile on one or more of the four outcome measures, the ACO would share in savings at a lower rate, reflective of the quality performance score.

MGMA comment: MGMA supports this proposal and strongly urges CMS to finalize this approach to the quality performance standard and shared savings. We agree with the agency that this reintroduced approach will ensure there is no “cliff” when determining savings.

CMS proposal (87 Fed. Reg. 46132): CMS proposes to extend the incentive for reporting eCQMs/MIPS CQMs through the 2024 performance year to align with the sunseting of the CMS Web Interface.

MGMA comment: MGMA supports the proposal to extend the incentive to report eCQMs/MIPS CQMs through the 2024 performance period. However, MGMA would strongly recommend CMS provide greater incentives for ACOs transitioning to eCQM reporting before the 2025 performance year.

Reporting digital quality measures will require ACOs to make changes to operational workflows, secure new technologic capabilities, and familiarize themselves with reconfigured measure sets, all of which require the attention of dedicated staff as well as an upfront financial investment for EHR upgrades. While CMS has provided an onramp to transition to digital quality measurement, upfront technological challenges and costs associated with reporting one eCQM is not substantially different from those associated with reporting three eCQMs.

Beneficiary Notification Proposal

CMS proposal (87 Fed. Reg. 46204): CMS proposes that instead of notifying assigned beneficiaries of ACO participation once per year, clinician must notify beneficiaries of ACO participation once per agreement period.

MGMA comment: MGMA supports this proposed update to the MSSP beneficiary notification process. Providing notifications to beneficiaries on an annual basis creates significant administrative burden for practices, without benefits to the patients. Many member group practices have expressed concerns about

the beneficiary notification process, as it creates additional confusion for the patient that doesn't fully understand the MSSP or an ACO.

The annual process is overly burdensome for ACOs. Assigned Medicare beneficiaries may not be able to fully understand the complexities of what an ACO is, and this necessitates providers take significant additional time to explain benefits of the program to patients. Many patients do not understand that participation in an ACO does not impact any of their Medicare benefits, nor does it require the beneficiary to complete any additional paperwork. However, under current rules, practices must spend valuable time reexplaining the program to patients once per year.

MGMA urges CMS to finalize this policy as proposed to alleviate the burden for practices and free up additional time and resources that can otherwise be spent on providing improved patient care.

Medicare Part B Payment for Preventive Vaccine Administration Services

CMS proposal (87 Fed. Reg. 46221): CMS proposes to codify Medicare coverage for COVID-19 vaccinations under Medicare Part B and adjust payment for the COVID-19 vaccines with the payment amount for the administration of other Part B vaccinations, effectively reducing the payment for the administration of the COVID-19 vaccine from \$40 to \$30 on the Jan. 1 following the conclusion of the declared COVID-19 PHE.

MGMA comment: During the pandemic, CMS acted quickly to establish coding and payment structures for billing COVID-19 vaccines and established a payment rate of \$40 to cover the associated costs of administering these novel vaccinations. MGMA is concerned that the proposed 25% decrease in payment for the administration of the vaccines will inadequately cover the associated costs and result in a decrease in administrations.

In the proposed rule, CMS asserts that post-pandemic the costs associated with administering the COVID-19 vaccines will decline post-pandemic and align with the costs of administering other vaccines in practices. However, unique supply challenges, persistent staffing constraints, and the need for critical patient education on the importance of the COVID-19 vaccine will continue to require higher reimbursement for the administration of the vaccine beyond the Jan. 1 following the end of the declared COVID-19 PHE.

During the pandemic, COVID-19 vaccines were supplied locally and distributed to providers. Each practice only provided certain brands of the vaccine, dependent on the supply from the government and the ability to store them. After the pandemic, as practices directly obtain vaccines, supply may change, formulations will continue to be developed for this novel vaccine and, consequently, will require practices to invest in new technologies, appropriate storage, and workflows to ensure proper administration.

In addition, staffing shortages, specifically among nursing staff, will create significant challenges for practices in maintaining adequate staff to administer COVID-19 vaccines. According to the American Nurses Association, in CY 2022 the number of available jobs for qualified registered nurses will be the top available employment opportunity across the country. The US Bureau of Labor Statistics projects a 275,000 nursing shortage between 2020 and 2030.⁸ Until the vaccinations for COVID-19 are stabilized

⁸ Haddad LM, Annamaraju P, Toney-Butler TJ. Nursing Shortage. [Updated 2022 Feb 22]. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2022 Jan.

and only offered annually with other seasonal vaccines, practices are required to maintain nursing staff, separate from other staffing levels, to meet the need and administer COVID-19 vaccines.

Further, as the first COVID-19 vaccines were developed in 2020, patient education remains a critical component of expanding the number of patients that receive the appropriate COVID-19 vaccinations. The novel nature of the vaccine increases the number of individuals that are hesitant to receive it. Preventive vaccines remain to be the most effective mechanism to slow the spread of COVID-19 and help the nation continue to recover from the height of the pandemic. Maintaining adequate vaccination rates to approach herd immunity among the population require practices to spend significant time with patients to communicate the importance of receiving a complete vaccine.

MGMA recommends CMS maintain the \$40 administration fee for at least two years beyond the termination of the COVID-19 PHE to ensure practices can continue to supply and administer these vaccines critical in preventing the continued spread of the virus.

Electronic Prescribing for Controlled Substances (EPCS)

Timing for Issuing Non-compliance Letters

CMS proposal (87 Fed. Reg. 46238): CMS proposes to extend the existing noncompliance action of sending letters to non-compliant prescribers for the EPCS program implementation year (Jan. 1, 2023 through Dec. 31, 2023) to the following year (Jan. 1, 2024 through Dec. 31, 2024).

MGMA comment: MGMA supports CMS' proposal to extend the enforcement policy of sending letters to physician practices who are not in compliance. There are many benefits for medical groups to adopt EPCS in their practices (i.e., workflow efficiencies, public health improvements, increases in patient safety, etc.). However, due to challenges from the COVID-19 pandemic, there are prescribers who have not had the ability to upgrade technology used for EPCS. Additionally, since group practices still face uncertainty regarding certain Drug Enforcement Administration (DEA) requirements, this proposed extension will give vendors and practices the time needed to adjust products to align with DEA regulations.

Cases of Recognized Emergencies

CMS proposal (87 Fed. Reg. 46239): CMS proposes to use the PECOS address instead of the NCPDP Pharmacy Database address to determine whether the exception is applicable. CMS is concerned that not all prescribers would be enrolled in Medicare and therefore their addresses would not be in PECOS. In situations where prescribers do not have a PECOS address, CMS proposes to use the prescriber address in the National Plan and Provider Enumeration System (NPPES) data. Additionally, CMS seeks public comment on whether using NPPES, NCPDP, or some other database is appropriate when there is no prescriber address in PECOS.

MGMA comment: MGMA supports this proposal as eligible clinicians participating in the MIPS program are already accustomed to updating their contact information in PECOS and PECOS is used to determine if the physician is an area that has been affected by extreme and uncontrollable circumstances. Should a provider need to apply for an EPCS exception, it would be based on where the prescriber is located, not where the pharmacy is located, in which the extreme and uncontrollable circumstance could differ. This proposal should streamline eligibility when disasters occur.

Request for Information Relating to Potential Future EPCS Penalties

CMS proposal (87 Fed. Reg. 46240): CMS also seeks public comment on additional penalties that CMS may impose to enforce the EPCS requirement. Such penalties would go into effect no sooner than Jan. 1, 2025, if CMS extends the timeframe during which they will issue non-compliance letters.

MGMA comment: While MGMA supports the move to EPCS for the various benefits outlined in the proposed rule and encourages practices to adopt EPCS as early as possible, we acknowledge various circumstances outside of the practice's control that prevent electronic prescribing, such as making difficult and costly technological upgrades necessary for EPCS, lack of interoperability between medical practices and pharmacies, high-cost implementation, and limited broadband access.

If CMS chooses in future rulemaking to implement further penalties for non-compliance, we encourage the agency to provide flexibility, offer assistance to practices who have not yet adopted EPCS, and work closely with the provider stakeholder community to ensure that the proposed penalties are appropriate. MGMA believes that CMS should be clear about why a practice is not in compliance and afford the practice an opportunity to come into compliance.

Quality Payment Program (QPP): MIPS and APMs

Merit-based Incentive Payment System (MIPS)

Automatic Extreme and Uncontrollable Circumstances (EUC)

During the COVID-19 pandemic, CMS provided flexibilities for MIPS eligible clinicians to apply and receive reweighting of performance categories under MIPS. Practices leaned on these flexibilities to ensure they were not financially penalized when focused on responding to the pandemic. MGMA urges CMS to apply a similar policy in for the 2022 performance year and apply the automatic EUC policy to individual MIPS eligible clinicians and permit groups and APM Entities to apply for reweighting for one or more performance categories.

While ensuring beneficiaries continue to receive the highest quality of care possible, it is critical that administrative requirements are flexible to permit practices to divert critical resources to ensure practices can respond appropriately to the COVID-19 pandemic. The COVID-19 pandemic continues to have resounding impacts on group practices, compounded by staffing constraints,

MIPS Quality Performance Category

Data Completeness Threshold

CMS proposal (87 Fed Reg. 46277): CMS proposes to increase the data completeness criteria threshold for the CY 2024 and 2025 performance periods from 70 percent to 75 percent.

MGMA comment: We disagree with the proposal to increase the data completeness threshold to 75 percent in the Quality performance category. Data completeness thresholds create unrealistic administrative burdens for practices in MIPS and require groups to predict the measures that they will likely meet completeness thresholds for in order to report a given measure.

In lieu of a percentage-based threshold, MGMA reiterates our recommendation to consider using a minimum number of patient policy offers greater predictability and stability for group practices. For cost measures, the agency generally requires only 10, 20, or 35 patient encounters to meet a reliability score of

0.4. For quality measures, MGMA encourages CMS to consider a data completeness threshold that meets a minimum reliability score of 0.80, which would increase the confidence that clinicians and groups have on their quality measure performance scores and comparisons. Moving to a minimum number of patients or some other predictable methodology also facilitates the planning of resources and staffing required for this effort.

As the agency looks to streamline the MIPS program with the creation of MVPs and the reporting of more meaningful measures, MGMA urges CMS to update the quality reporting requirements to align with other goals within the program. We believe this alternative approach will significantly improve quality reporting and alleviate administrative burdens.

MIPS Promoting Interoperability Category

Query of Prescription Drug Management Program (PDMP) Measure

CMS proposal (87 Fed. Reg. 46289): CMS proposes to require the Query of PDMP measure for all MIPS eligible clinicians participating in the Promoting Interoperability program. CMS proposes to permit certain exceptions to the consultation of a PDMP under two circumstances:

1. If the MIPS eligible clinician is unable to electronically prescribe Schedule II, III, or IV drugs in accordance with applicable law and
2. If the MIPS eligible clinician writes fewer than 100 permissible prescriptions during the performance period.

MGMA comment: PDMPs offer increased accountability in opioid prescribing practices by providing information directly to the clinician that facilitates the coordination of multiple medications. They have also been shown to help prevent adverse drug interactions. We agree 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.

MGMA reminds CMS that there are clinical situations where the provider-patient relationship or the nature of the patient's illness does not require consultation of the PDMP nor verification of an opioid treatment agreement. These additional circumstances that should be added to the exclusion criteria could include long-established chronic illnesses or medical diagnoses such as cancer, post-surgical patients, or patients under care of hospice. The decision regarding which clinical situations to apply to exclusion criteria should be left solely to the discretion of the eligible clinician.

Additionally, we agree with CMS that it is appropriate that clinicians continue to use a "yes/no" attestation to satisfy the Query of PDMP measure.

CMS proposal (87 Fed. Reg. 46290): CMS proposes to expand the definition of the Query of PDMP measure to include Schedules II, III, and IV. Currently, the Query of PDMP measure only requires conduct a PDMP query for prescriptions under Schedule II.

MGMA comment: We do not support the expansion of the Query of PDMP to include Schedules III and IV. Expanding the PDMP query requirements to include drugs in Schedules III and IV are not clinically appropriate to achieve the goals of reducing the opioid epidemic and should not require this additional step.

MIPS Final Score and Payment Adjustments

MGMA recognizes that the MIPS Exception Performance bonus expires under statute after the current 2022 performance year/2024 payment year. However, we are concerned that the expiration of the additional \$500 million to support positive payment adjustments under the program will significantly impact practices. In a CY 2021 survey of over 400 medical group practices, 93% of respondents stated that the positive payment adjustment under the MIPS program does not cover the cost of time and resources spent preparing for and reporting under the program.⁹

Under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), MIPS is intended as an on-ramp for practices to invest in quality reporting prior to participating under an alternative payment model that holds the practice financially responsible for a larger portion of the care provided. Since the program's inception, practices have expressed concerns with the complexity of the program and the usefulness of the data in supporting meaningful improvements to quality of care provided in the practice. As the positive adjustments under the program decrease, used to offset costs of reporting, there will be lesser incentives to invest in improvements under the MIPS program. MGMA is concerned with the downstream impacts of the expiration of the Exceptional Performance bonus on the investment across the healthcare industry in quality improvement activities.

Further, under MACRA, the 2023 performance year is the first year that the MIPS program will be fully phased in according to statute, with category weights and performance thresholds established after intended years of phasing in such policies. While MIPS program policies have been fully introduced, practices have yet to achieve a maximum payment adjustment in MIPS in any performance year. Positive payment adjustments have been minimal across all performance years, even for high performers.

Performance Threshold

CMS proposal (87 Red. Reg. 46258): CMS proposes to use the CY 2019 MIPS payment year as the prior period and the rounded mean of 75 points as the MIPS performance threshold for the 2023 MIPS performance year/2025 payment year.

MGMA comment: As stated in previous rulemaking cycles, MGMA is concerned with the accelerated increase in the performance threshold under the MIPS program and we urge CMS to use any enforcement authority to lower the MIPS performance threshold. During the COVID-19 pandemic, the MIPS performance threshold increased from 30 points in the 2019 performance year to 75 points in 2023. Simultaneously, during this time period, group practices fervently responded on the frontlines of the pandemic, many relying on the automatic MIPS reweighting policy to avoid significant major cuts in Medicare payment.

Further, as eligible clinicians and groups begin the transition to participating under MIPS Value Pathways, practices will require additional flexibilities to avoid significant negative payment adjustments as the report under this new pathway.

MIPS Value Pathways (MVPs)

As a new reporting pathway under the MIPS program, MGMA supports the goal to streamline reporting, make reporting of measures more meaningful to eligible clinicians, and report appropriate data to patients

⁹ MGMA Annual Regulatory Burden Report. October 25, 2021. <https://www.mgma.com/resources/government-programs/mgma-annual-regulatory-burden-report-2021>

to support transparency in the healthcare system. However, MGMA is concerned the MVP reporting pathway creates additional burdens for practices without delivering on goals to improve the MIPS program.

Only a fraction of practices (13%) intend to voluntarily report under an MVP beginning in the 2023 performance year.¹⁰ While CMS created some incentive for practices to report under an MVP, there fails to be meaningful incentive to transition to reporting under this new pathway. MGMA recommends CMS provide additional guidance and education to practices about the goals of MVPs to provide practices with the information necessary to make an informed decision about the most appropriate quality reporting pathway for each practice.

MVP Maintenance and Development Process

CMS proposal (87 Fed. Ref. 46266): CMS proposes a new MVP development and maintenance process to better incorporate stakeholder feedback into the process. CMS proposes to establish an annual process, beginning in January of each calendar year, to seek feedback on MVPs under development for the upcoming rulemaking cycle. Similarly, CMS proposes to accept feedback on existing MVPs in an annual maintenance process.

MGMA comment: We appreciate the ongoing engagement to improve the Quality Payment Program and reporting under MIPS. MGMA would encourage CMS to widely communicate the availability of this new MVP process to ensure practices across specialties are able to provide meaningful feedback on the MVP process. We urge CMS to finalize the MVP development process as an important tool to improve transparency under the MIPS program.

Subgroup Reporting

CMS proposal (87 Fed. Reg. 46127): CMS reiterates its policy to require multispecialty groups to form subgroups beginning in the 2026 performance year in order to report under an MVP.

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. CMS should maintain subgroup reporting as an optional pathway under MVPs and should encourage subgroups be composed of clinicians of multiple specialties, as appropriate, to encourage team-based care.

MGMA also has concerns about the timing of implementing subgroup reporting requirements. CMS will require all multi-specialty groups form subgroups in order to report under an MVP beginning in 2026. This creates significant burdens for multi-specialty groups that will not have an appropriate MVP to report during the first several years of the program. Additionally, subgroup reporting will increase reporting burden and complexities for group practices that are required to form multiple subgroups and report on multiple MVPs.

CMS proposal (87 Fed. Reg. 46268): CMS proposes to identify eligible clinician specialty from Medicare Part B claims for purposes of identifying specialty in subgroup reporting under and MVP.

MGMA comment: MGMA urges CMS not finalize its proposal to identify specialty for subgroup reporting under an MVP and instead permit a group to self-identify the most appropriate specialty during the MVP registration process. This proposed alternative process will ensure that eligible clinicians

¹⁰ MGMA poll, Physician Fee Schedule Q&A, Aug. 23, 2022.

identify the most appropriate specialty, and the most appropriate measures, that reflect the clinical care they provide.

Further, the CMS proposed subgroup identification process will create complexities for nurse practitioners and physician assistants, as these clinician types do not identify their clinical practice area on a claim. As a result, group practices may be required to form additional subgroups and report under additional MVPs even if it would be clinically appropriate for the entire practice to report as one group under a single MVP. These additional uncertainties that are incorporated into the MIPS program with the introduction of subgroup reporting requirements add significant and unnecessary administrative burdens.

Alternative Payment Model (APM) Proposals

Qualifying APM Participant (QP) and Partial QP Thresholds

CMS request for comment (87 Fed. Reg. 46339): CMS reaffirms, consistent with statute, that the QP threshold will remain at 50 percent for the payment amount method and 35 percent for the patient count method and partial QP thresholds will remain at 40 percent for the payment amount method and 25 percent for the patient count method for the 2021 and 2022 performance years (2023 and 2024 payment years, respectively).

CMS proposes that beginning with the 2023 performance year, the QP threshold will increase to 75 percent for the payment amount method and 50 percent for the patient count method and the partial QP threshold will increase to 50 percent for the payment amount method and 35 percent for the patient count method.

MGMA comment: MGMA strongly opposes the introduction of the significant increases in QP and partial QP thresholds beginning in the 2023 performance year. Stability with quality reporting is critical to incentive increased participation in an advanced APM. With already declining growth in advanced APMs, these unrealistic thresholds will further impact participation.

We urge CMS to call on Congress to act and reduce the QP thresholds to support the continued transition in value-based care arrangements.

Request for Information APM Entity Level Determinations

CMS request for comment (87 Fed. Reg. 46337): CMS is seeking comment on potential transitioning QP determinations from the APM entity level to the individual clinician level.

MGMA comment: MGMA does not support the transitioning of QP determinations from the APM entity level to the individual clinician level. CMS anticipates that this transition of QP determination will prevent APMs from excluding specialists from participating in an advanced APM. However, based on our members' experience, specialists will be more likely to participate in an advanced APM if the QP determination is made at the APM entity level, rather than the individual level. Many specialists will not individually qualify as a QP or partial QP, however, under APM entity level determinations will more likely to qualify.

MGMA is concerned that this policy, in conjunction with other policy directives from the CMS Innovation Center, will severely impact specialist participation under an advanced APM and more broadly within the transition toward value. With fewer specialty-focused models underway and the consideration of policies, such as transitioning to individual level QP determinations, MGMA is deeply

concerned specialists will not have incentive to meaningfully engage in value-based care initiatives, driving a wedge within the healthcare industry.

While primary care remains critical to the success of many value-based care arrangements with care coordination and leading patient-centered care teams, specialists are uniquely positioned to support complex conditions and high-cost services. As mentioned throughout our responses to other CMS policy proposals, MGMA and our member group practices champion a team-based approach to care. We are concerned that transitioning from APM level QP determinations to individual clinician determinations will undermine previous strides made in advancing value-based care.

Request for Information on Quality Payment Program Incentive Beginning in Performance Year 2023

CMS request for comment (87 Fed. Reg. 46332): Beginning in the 2023 performance year/2025 payment year, additional financial incentives under the Quality Payment Program are no longer distributed to eligible participants. CMS seeks comments on the impact of the expiration of the 5% APM Incentive Payment on practice participation in alternative payment models and considerations made when determining whether to participate under MIPS or an APM.

MGMA comment: The 5% APM Incentive Payment bonus is a critical tool for the transformation to value-based care. QPs are eligible to receive the 5% lump sum payment amount based on participation status in an applicable advanced APM model. The incentive payment is provided after the applicable performance period and is based on Medicare Part B claims. This funding stream is an important tool used by practices of all sizes participating in a value-based care arrangement, especially new entrant participants.

While many MGMA member group practices have experience participating in a value-based care arrangements, there remains to be gaps in participation options offered by the CMS Innovation Center. Medicare does not offer an advanced APM that is clinically relevant to 80% of group practices.¹¹ The 5% APM Incentive Payment is an important financial support for practices engaging in risk arrangements for the first time. MGMA is strongly advocating Congress extend the 5% APM Incentive Payment to support to continued growth and participating in value-based care arrangements.

Expiration of the 5% Incentive Payment and Participation under an APM

The expiration of the 5% lump sum APM Incentive Payment will likely cause reductions in participation in advanced APM models, especially among new entrant participants. The incentive payment was a significant amount of additional funding for many practices used to bolster participation in value-based payment arrangements. Practices used the funding to support community wrap around services expanding care beyond the traditional clinical setting, hired new staff specializing in care coordination, and expanded types of services provided championing patient-centered care.

The goal for participating under a value-based care arrangement is to provide high quality and cost-effective care for patients. Practices that are successful under such payment arrangements are able to transform patient care that prioritizes high-value services. To achieve these goals under a value-based care arrangements, group practices must invest significant time and capital to establish new process, hire new staff, and transform care delivery pathways for their patient population.

¹¹ MGMA Annual Regulatory Burden Report. October 25, 2021. <https://www.mgma.com/resources/government-programs/mgma-annual-regulatory-burden-report-2021>

Further, APM participants are not only facing the expiration of the incentive payment, but also facing significant financial and practice operations challenges. In CY 2022, the 2% Medicare Sequester was fully phased back in, and in CY 2023, practices will face a 4.42% reduction in the physician conversion factor and a potential 4% PAYGO sequester. Not only are practices absorbing targeted cuts to Medicare reimbursement, but they are also struggling financially during record-breaking inflation. These financial challenges are coupled with ongoing staffing issues at all levels - administrative and clinical.

With the onslaught of many significant financial challenges, without additional financial support, practices may abandon extraneous costs that can be cut, including participation in voluntary value-based care arrangements. MGMA believes group practices should have the opportunity and support required necessary to participate in an advanced APM as value-based care arrangements provide an opportunity for clinical care transformations and improved patient care. However, the expiration of the 5% APM Incentive Payment will negate previous strides made in increasing participation in advanced APMs.

MIPS versus APM Participation Incentives

Without achieving QP status under an advanced APM, most clinicians would instead be required to report under the Merit-based Incentive Payment System (MIPS) pathway under the Quality Payment Program (QPP). With the minimal positive payment adjustments under the MIPS program, most group practices do not perceive any advantages of participating in MIPS over an advanced APM. Practices have experienced historical challenges with the MIPS program, including reporting burdens, program complexities, and minimal maximum positive payment adjustments.

Compounding Financial Constraints

Many MGMA member practices participate in an advanced APM and share in CMS' goal of advancing value-based care initiatives and providing the highest quality care to Medicare beneficiaries across the nation. However, in combination with the program requirements under value-based care models and significant projected payment cuts to Medicare, as well as the expiration of the 5% APM Incentive Payment, many group practices will consider abandoning participation under a value-based payment arrangement. For instance, a two-physician family practice in suburban Missouri shared with MGMA, "We are already overwhelmed with meeting the requirements for Primary Care First. The reduced payment for each visit impacted us significantly more than predicted. Any further cuts to Medicare payments could well lead us to withdraw from this APM."

The ongoing staffing crisis and rampant inflation contribute to an even more precarious environment for group practices. Retention and recruiting of qualified staff have been incredible barriers to growth and has caused significant disruptions in providing timely care to patients. Oftentimes, when staffing is strained, investments into value-based care initiatives are the first thing cut. For example, nursing staff strictly dedicated to collecting information related to quality of care may be required to provide clinical support and intake patient information.

The transition to investing in value-based care arrangements is contingent on building the momentum within the healthcare system. Updating clinical practice guidelines and implementing new care coordination processes requires capital investment, as well as critical dedication and investment among the staff. Losing the momentum in the transition to value-based care will have long-term resounding impacts on the journey to supporting practice participation in meaningful value-based care initiatives.

Conclusion

We appreciate the opportunity to share our comments regarding the proposed changes to the Medicare PFS and QPP and to offer recommendations to improve and simplify these policies to support group practices as they care for patients. Should you have any questions, please contact Claire Ernst, Director of Government Affairs, at cernst@mgma.org or 202.293.3450.

Sincerely,

/s/

Anders Gilberg

Senior Vice President, Government Affairs