May 27, 2021

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

Dear Administrator Brooks-LaSure,

On behalf of the nation's medical group practices, I extend my warmest congratulations on your confirmation as Administrator of the Centers for Medicare & Medicaid Services (CMS). Given your experiences serving as a senior CMS and Department of Health and Human Services official and as a professional staff member on the U.S. House Ways and Means Committee, we believe you share a common goal of empowering physician practices to deliver high-quality, cost-effective care. The Medical Group Management Association (MGMA) stands ready to work with you and your colleagues at CMS in crafting regulations that promote innovative, high quality, and efficient care delivery while reducing regulatory burden.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 group medical practices ranging from small private medical practices to large national health systems representing more than 350,000 physicians.

As you assume your role at CMS, MGMA requests your consideration of the following opportunities to significantly reduce the regulatory burden on physician practices and improve the quality and efficiency of healthcare delivery in this country.

PRIOR AUTHORIZATION

- **Include Medicare Advantage plans in scope of the CMS Interoperability and Prior Authorization Rule.**[1] CMS' proposed rule would place new requirements on Medicaid and CHIP managed care plans, state Medicaid and CHIP fee-for-service programs, and Qualified Health Plans (QHP) issuers on the Federally-facilitated Exchanges (FFEs) to improve the electronic exchange of health care data, and streamline processes related to prior authorization. By restricting the applicability of these proposed requirements to a small number of health plans,

[1]Medicaid Program; Patient Protection and Affordable Care Act; Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information for Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-facilitated Exchanges; Health Information Technology Standards and Implementation Specifications, 42 CFR Parts 431, 435, 438, 440, and 457 (2020).

CMS is virtually guaranteeing that industry implementation of these automated solutions will be limited and do little to alleviate the current level of administrative burden on physician practices.

TELEMEDICINE

- **Allow permanent coverage of audio-only services.** Telephone visits have provided a lifeline to patients who are unable to attend visits in person or participate in telehealth visits due to lack of broadband access or necessary equipment to facilitate the visits. Throughout the COVID-19 public health emergency (PHE), MGMA has received feedback from group practices on the incredible value of audio-only services. In an August 2020 poll conducted by MGMA, 82% of respondents reported that they had billed an audio-only service during the public health emergency.[2] CMS previously indicated it would not continue to reimburse these services separately past the conclusion of the COVID-19 PHE, because it believes the longstanding regulatory interpretation of "telecommunications system" precludes the use of audio-only technology for purposes of Medicare telehealth services outside the PHE.[3] We urge CMS to reverse its position and continue to provide payment for these services after the PHE so physician practices can continue to treat vulnerable patients.
- **Leverage CMS' authority to make other telemedicine flexibilities permanent.** In addition to making audio-only services permanent past the conclusion of the PHE, MGMA encourages CMS to use its regulatory authority to make additional flexibilities permanent, such as reimbursing telehealth visits at the higher, in-person rate to ensure that telehealth remains a viable method of care delivery in the future. We also encourage CMS to support permanently eliminating the geographic and originating site restrictions contained in 1834(m) of the Social Security Act—requirements that have prohibited many vulnerable beneficiaries from receiving care via telehealth prior to the pandemic.

THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

- **Implement an automatic hardship exception for participants in the Merit-based Incentive Payment System (MIPS) for the 2021 performance year.** MGMA appreciates that CMS offered this policy to individual MIPS participating clinicians for the 2020 performance year. As we expect the coronavirus will continue to impact the healthcare system, continued flexibility is needed to support medical groups and avoid creating additional burden, such as a requirement to submit a hardship application.

- **Provide meaningful reform and transparency in the methodology that CMS uses to calculate scores in the MIPS cost category.** The MIPS cost category is problematic in that the total per capita cost (TPCC) and Medicare spending per beneficiary (MSPG) measures unfairly penalize providers by holding them accountable for costs they cannot control. Practices that see patients only a handful of times in a year for inexpensive services report being held responsible for the entire cost of care for the patient. Additionally, we request CMS improve feedback and

[2] MGMA poll, Physician Fee Schedule Q&A, Aug. 26, 2020.
[3] Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/ Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID–19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID–19, 42 CFR Parts 400, 410, 414, 415, 423, 424, and 425 (2020).

offer comparative information so that providers can take meaningful action to improve their cost measure performance.

- **Implement MIPS Value Pathways (MVPs) after the conclusion of the COVID-19 pandemic and after CMS receives sufficient input from the medical practice community.** MGMA supports CMS' efforts to create a MIPS program that is more clinically relevant, less burdensome, and streamlines the four disparate performance categories into a more cohesive program. However, we are concerned that the current MVP framework does not make significant progress in achieving these priorities and could potentially delay the efforts to develop new alternative payment models (APMs). MGMA stands ready to work with CMS on development of MVPs and help facilitate feedback on operational concerns and administrative issues well-known to our members.

- **Maintain MIPS performance category weights and performance thresholds from 2021 into 2022.** As practices continue to battle the lingering effects of COVID-19, MGMA strongly urges CMS to extend the 2021 reporting thresholds and category weights through the 2022 performance year.

- **Offer MIPS complex patient bonus for 2021 performance year.** Due to continued challenges that have resulted from delayed care due to the COVID-19 pandemic, many practices are seeing patients that have exacerbated medical concerns. Added to this complexity, practices are now caring for patients with long-term health impacts of contracting COVID-19, otherwise known as COVID-19 "long-haulers." MGMA encourages CMS to offer the 10-point complex patient bonus through the 2021 MIPS performance year.

ALTERNATIVE PAYMENT MODELS (APMs)

- **Support the development of new, voluntary, physician-led APMs that meet the needs of practices of varying types, sizes, and specialties to inherently drive more widespread participation in value-based care initiatives**. We support the voluntary transition of medical groups from traditional fee-for-service payments to value-based reimbursement. We encourage CMS to design and implement APMs that provide sufficient supports for group practice participants and appropriate financial incentives and regulatory flexibilities to sustain participation.

- **Offer participants in advanced APMs the option to mitigate downside financial risk in exchange for reduced upside risk for all performance years impacted by the COVID-19 PHE.** We also recommend that CMS offer additional funding opportunities to support group practices participating, or considering participation, in APMs in 2021 and 2022. 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.

- **Reevaluate the APM Performance Pathway (APP) for MIPS APMs.** The APP does not take into consideration the diversity of MIPS APMs and instead would subject them all to the same quality measure set. This policy is counter to CMS' goals in other areas of the Quality Payment Program (QPP), such as MVPs and specialty measure sets, to make MIPS more clinically relevant to specialists. We are particularly concerned about the potential negative impact the APP will have on non-ACO MIPS APMs and recommend that CMS take more time to consider stakeholder feedback on how to best measure APMs subject to MIPS reporting.

- **Consider how to move more APM participants away from MIPS reporting when they fall short of qualified participant (QP) thresholds and into the Advanced APM track of the QPP, as was Congress's intent when enacting MACRA.** We encourage CMS to consider modifying its financial risk standard to allow more APMs to meet the definition of an Advanced APM. We also believe CMS could modify its policies around QP thresholds to add more flexibility into the patient count threshold, as is permitted by MACRA.

LABORATORY PAYMENT

- **Implement PAMA in a manner that is least burdensome for applicable laboratories to report and adopt a more accurate reimbursement rate formula to sustain the viability of physician office laboratories (POLs).** We are concerned that basing the Clinical Laboratory Fee Schedule (CLFS) on the private payer rates paid to independent labs alone would artificially deflate the price of lab services and consequently force POLs to cease offering point-of-care testing for patients. The data collection process must also be more inclusive and representative of the entire market of POLs rather than skewing towards large commercial labs. Prior to resuming these laboratory payment cuts in 2022, we encourage CMS to reevaluate its payment methodology for CLFS rates and implement improvements to its data collection processes.

As the voice for the country's medical group practices, MGMA remains committed to promoting policies that enhance the ability of our members to provide high-quality, cost-effective care to the millions of patients they serve routinely. We look forward to working with you to advance constructive solutions to better equip the nation's physician practices in delivering equitable and high-quality care. Should you have any questions, please contact Claire Ernst at cernst@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs