



Aug. 21, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program; CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the final rule with comment period entitled, “Medicare Program; CY 2018 Updates to the Quality Payment Program,” published on June 30, 2017, with file code CMS–5522–P. The Association welcomes many of the proposals in this rule that would afford physician group practices with stability and flexibility during the second year of the Quality Payment Program (QPP) and offers recommendations to reduce burden in the Merit-Based Incentive Payment System (MIPS) and support physician practices as they transition to alternative payment models (APMs).

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

Repealing the problematic sustainable growth rate and retiring a hodgepodge of quality reporting programs, the Medicare Access and CHIP Reauthorization Act (MACRA) charted a value-based trajectory for the Medicare payment system by valuing innovative, patient-centric and efficient care delivery over check-the-box bureaucracy. However, as implemented by the previous Administration, MIPS is overly complex and rewards the quantity of reporting rather than the quality of care provided to patients. At the same time, the Advanced APM pathway is far too narrow. At this critical juncture in Medicare’s transition from fee-for-service toward value-based reimbursement, CMS has an opportunity to reset and align the QPP with the original intent of MACRA to support physician practices as they transform the way they deliver care.

According to a recent study of more than 750 MGMA member practices, the QPP is the most burdensome regulatory issue facing group practices in 2017. Although the vast majority of respondents are participating in MIPS, more than 70% of respondents were very or extremely concerned about the lack of clinical relevance to patient care. Articulating a theme we hear regularly across the country, one practice leader wrote: “We are a GI single specialty clinic. I can use the specialty measures for the MDs but not the mid-level providers as they don’t apply. I have to have two sets of MIPS requirements and measures. It’s extremely burdensome.”

Similarly, a 2016 *Health Affairs* study of MGMA member practices cited in this proposed rule (82 Fed. Reg. 30219) found that each year physician practices in four common specialties spend, on average, 785 hours per physician and more than \$15.4 billion on quality measure reporting programs. As the study cites, the majority of time spent on quality reporting consists of “entering information into the medical record only for the purpose of reporting for quality measures from external entities,” and nearly three-quarters of practices stated their group was being evaluated on quality measures that were not clinically relevant. Congress recognized the pitfalls of these programs in driving clinicians’ time away from patients and toward paperwork, and, as a result, replaced them with MIPS.

MGMA is pleased CMS has signaled a renewed interest in engaging with the physician community to reduce the regulatory burden in MIPS and align it with group practices’ ongoing efforts to improve patient care. To further the agency’s goal to emphasize “high-value care and patient outcomes while minimizing burden on eligible clinicians” (82 Fed. Reg. 30011), MGMA offers the following recommendations:

- **Permanently shorten the minimum quality and advancing care information (ACI) reporting periods to any 90 consecutive days** using sampling and attestation methodologies that ensure statistical validity. Participants should have the option to report more data as needed.
- **Simplify MIPS and reduce redundancies by awarding cross-category credit.** As implemented, MIPS reflects a continuation of the agency’s historically siloed approach to quality reporting, consisting of four programs under one umbrella. To reduce burden, CMS should award credit in multiple categories for overlapping efforts. For instance, clinicians should receive ACI credit when they report quality measures via end-to-end electronic reporting using certified EHRs.
- **Finalize the proposed expansion of the low-volume threshold and refine the way the low-volume threshold applies to group practices.** CMS should mirror its own policy for non-patient facing eligible clinicians (ECs) and scale the low-volume threshold to the group practice level, exempting a group from MIPS if 75% or more of its ECs individually fall below the low-volume threshold or the group’s average Medicare allowed charges or Medicare patient population falls below the threshold.
- **Finalize the proposal to allow MIPS and APM participants to use 2014 or 2015 CEHRT in 2018** and extend this flexibility through 2020.
- **Stabilize the quality performance category** by maintaining the 50% data completeness threshold and preserving the three-point floor for scored quality measures. Further improvements to the category include eliminating the outcome or high-priority measure requirement, removing the administrative claims measure and maintaining “topped out” measures.
- **Avoid adding complexity to the IA performance category** by continuing to allow ECs and groups to attest to completion of activities, not removing any IA activities, and not requiring a future minimum participation threshold. We also strongly urge CMS not to require a threshold reporting requirement for groups attesting to IAs.

- **Streamline the ACI performance category** by deeming ECs and groups using certified EHR technology as meeting the ACI base score requirements and automatically awarding 50% of the full ACI score. CMS should also deem ECs and groups attesting to completing one or more of the Improvement Activities (IAs) requiring CEHRT to have met the ACI base score requirements and automatically receive 50% of the ACI score.
- **Reweight the MIPS cost performance category to zero** until CMS has extensively tested the new episode-based measures, reformed the patient attribution methodology, and implemented key aspects of this category, including patient relationship codes and risk adjustment recommendations from a forthcoming congressionally-mandated report.
- **Provide clear and actionable feedback about MIPS performance at least every calendar quarter**, as recommended by the statute. Without transparent criteria and timely feedback, MIPS is essentially a reporting exercise that enters data into a “black box” only understood by CMS, rather than a useful barometer practices can leverage to drive clinical improvement.
- **Overhaul the Advanced APM criteria and expand the list of qualifying APMs** to include CMS Innovation Center models such as Medicare Shared Savings Program (MSSP) Track 1 ACOs and the Bundled Payment for Care Improvement (BPCI) models.
- **Seek opportunities to adopt private sector payment models and patient-centered medical home (PCMH) models as Advanced APMs.**

Merit-Based Incentive Payment System

Performance period

CMS proposal (82 Fed. Reg. 30034): In the 2017 QPP final rule, CMS established a full calendar year reporting period for the quality and cost performance categories beginning in 2018, while the ACI and improvement activities categories would continue to be any 90 days. CMS also finalized that ECs and groups who report less than 12 months of data would be required to report all performance data available from the applicable performance period. CMS does not propose any changes to these policies in the 2018 rule: CMS proposes to maintain full-year reporting period for quality and cost in 2018 and beyond. The agency also proposes to maintain a continuous 90-day reporting period for improvement activities and ACI during 2019.

MGMA comment: MGMA strongly opposes a full calendar-year reporting period for the quality performance category of MIPS and urges CMS to establish a 90-day reporting period minimum – or 90-day reporting floor – for all MIPS categories that require data submission by group practices and ECs, including quality and ACI. Contrary to statements made throughout the proposed rule, physician practices must take many steps prior to the start of the performance period to ensure that the proper systems are in place and the necessary data is being accurately collected throughout the performance year so that it can be properly submitted during the subsequent attestation period. For example, clinicians and practices must select the requisite number of clinically-relevant measures, train their staff, and often input the measure information as discreet data into the EHR. Otherwise, a third-party data submission vendor or registry cannot extract the necessary data, nor submit it to CMS, such that a full calendar-year of data is provided. Starting at the outset of the performance period is even more critical for clinicians who report via Part B claims, because quality code information must be included when the claim is processed for payment. Requiring ECs and group

practices to accomplish this heavy lift between early Nov. when the final policies and measures are released and Jan. 1 is unrealistic.

Moreover, if CMS truly intends to influence clinicians and practices to improve care by evaluating quality, cost, EHR use, and practice improvement metrics, desired evidence-based actions must be taken at the point of care, starting on the first day of the performance period. As a result, starting performance on Jan. 1, 2018, as proposed, would, at best, reduce MIPS participation from a thoughtful and concerted effort to improve the value of patient care into a sprint toward compliance out of sheer survival, or quite possibly evolve into a winner-take-all scenario in which the practices that already made investments in infrastructure and technology would excel, while less-resourced practices scramble to catch up or decide not to participate. MIPS offers the Administration a unique opportunity to hit the reset button and reestablish industry confidence in federal quality reporting programs.

We acknowledge that certain reporting options, such as reporting certain outcome-based measures, may require a lengthier reporting period than 90 days to ensure statistical validity, and we encourage CMS to permit groups to report data for longer periods of time in such circumstances. However, we strongly encourage CMS to look for opportunities to shorten the minimum statistically-valid reporting period across all data submission methods. When reporting all-payer data via QCDR, registry, or EHR, any 90-consecutive days should provide a sufficiently reliable data set.

Moving to a shorter reporting period would also allow for a number of program improvements. A 90-day reporting floor would reduce the administrative burden in MIPS, align the reporting period across MIPS categories, allow the agency to shrink the problematic two-year lag between performance and payment, and increase the timeliness and relevance of feedback, which could be provided on a quarterly basis, as recommended by Congress. Establishing a 90-day reporting floor would also give CMS an opportunity to set benchmarks based on more current data, rather than from four years prior to the payment year.

Low-volume threshold

CMS proposal (82 Fed. Reg. 30023): CMS proposes to increase the low-volume threshold to exclude ECs and groups that bill \$90,000 or less in Medicare Part B charges or see 200 or fewer Medicare beneficiaries. The agency projects approximately 134,000 additional clinicians will be excluded from MIPS under this revised definition of low volume.

MGMA comment: In MACRA, Congress recognized small practices often lack the infrastructure and resources to comply with complex quality reporting programs, particularly when Medicare patients make up a small portion of their patient mix, and established the low-volume threshold to mitigate adverse effects on small and rural practices. MGMA supports CMS' proposed increase of the low-volume threshold to reduce the burden on small practices and practices with a low Medicare patient population and mitigate the confounding variables solo practitioners and small groups face when compared against large, resource-rich group practices.

MGMA continues to question CMS' application of the same threshold at both the clinician and group practice level. This approach significantly disadvantages groups of clinicians who, in the aggregate, rarely care for Medicare patients, but include one or two members that actively participate in the program. MGMA urges CMS to extend its own logic behind setting a group practice equivalent for the non-patient-facing definition by exempting group practices when 75% or more of the national

provider identifiers (NPIs) who bill under the group's tax identification number (TIN) meet the threshold on an individual basis.

Finally, CMS should ensure that providers know where they fall in relation to the low-volume threshold in advance of the performance year. MGMA heard from dozens of group practices throughout the first half of 2017 who were wondering whether they would be required to participate in MIPS based on their Medicare patient and reimbursement volume. To avoid the same confusion and frustration experienced in 2017, CMS should clearly and accurately communicate MIPS eligibility information to clinicians and groups at the outset of the performance period.

Payment adjustment at NPI/TIN level

CMS proposal (82 Fed. Reg. 30146): CMS does not propose to change its policy that payment adjustments are made at the TIN/NPI level, regardless of whether the TIN/NPI was measured as an individual, group or APM Entity group during the applicable performance period.

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

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

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

Further, MGMA seeks clarification about how CMS applies the payment adjustment to ECs who billed Medicare Part B charges under more than one TIN during the performance period. The proposed rule reiterates that each NPI/TIN combination will be scored and a payment adjustment would apply in each TIN. In contrast, the CMS subregulatory document entitled, "An Introduction to Group Reporting," provides, "If a clinician billed Medicare Part B charges under more than one TIN during the performance period, CMS will take the clinician's highest final score from the performance period and assign the score to the MIPS clinician for that performance year. This includes: clinicians who work in multiple practices (creating a new TIN/NPI combination) during the

performance period and clinicians who submit data as part of a group and individually.” How does CMS apply a payment adjustment in scenarios in which an EC bills Medicare Part B under more than one TIN?

Small practice size determination

CMS proposal (82 Fed. Reg. 30019): CMS proposes to notify groups with 15 or fewer clinicians and solo practitioners of their small practice status in MIPS prior to the performance period based on historic claims data. The agency seeks comment about supplementing the claims-based determination with an attestation process that would allow small practices to attest to their size, which may have changed since the historic claims period.

MGMA comment: MGMA strongly supports advanced notification of all special statuses in MIPS, including small practice size. Without basic information about eligibility prior to the start of the performance period, physicians and group practices are disadvantaged and stuck in a holding pattern, preventing them from the necessary planning to position themselves for success in the program. MGMA also appreciates CMS’ recognition that group practice size can fluctuate as clinicians switch practices and retire, and we support a simple attestation process for small practices to attest to their real-time size if it has changed since the determination window. We urge CMS to limit the administrative difficulty of accessing the attestation portal, to align it with the other MIPS portals, such as the IA attestation portal, and to allow practice surrogates, including practice administrators, to attest on behalf of the group.

Virtual groups

CMS proposal (82 Fed. Reg. 30027): CMS proposes rules for forming a “virtual group” comprised of multiple solo practitioners and group practices with 10 or fewer ECs practicing under different TINs. Virtual groups would participate collectively in MIPS and be scored collectively. If finalized, interested clinicians and groups could request an eligibility determination prior to forming a virtual group to ensure they do not exceed 10 ECs and are not excluded under the low volume threshold. Virtual groups would be required to notify CMS of their formation by Dec. 1 of the year prior to the performance period and sign a written agreement. CMS would not allow changes to a virtual group election during the performance period. Group reporting policies would generally apply to virtual groups, which would be required to aggregate each participant’s quality, improvement activity and ACI data prior to submission to CMS. The agency projects 16 virtual groups will form for 2018.

MGMA comment: MGMA appreciates the recognition in MACRA and by CMS that the group practice model – whether real or virtual – is an optimal delivery system for furnishing high-value, efficient patient care. However, because there are many details that distinguish this largely untested and undefined mechanism from a group practice, MGMA urges CMS to consider renaming this option a “virtual network.” Unlike a group practice, which offers and coordinates a wide range of physician and related ancillary services under one roof in a manner that is seamless to patients, a virtual network would align multiple group practices and clinicians operating across the medical community to report in MIPS. Rather than creating confusion about the bounds of a virtual group, CMS should use its authority, as it did in changing the names of Meaningful Use and MACRA, to clarify this mechanism and rebrand it as the virtual network option.

MGMA welcomes the flexibility afforded in this proposed rule to form virtual groups without limit based on specialty designation, geography, or reporting mechanism. However, we are concerned CMS intends to impose limitations on virtual group arrangements and who may convene a virtual group. On

page 30032, CMS states the virtual group agreement “may not be between a virtual group and another entity, such as an independent practice association (IPA) or management company that in turn has an agreement with one or more TINs within the virtual group. Similarly, virtual groups should not use existing contracts between TINs that include third parties” (82 Fed. Reg. 30032). MGMA believes many of the group practice networks that would be positioned to clear the virtual group formation hurdles and succeed collectively in MIPS are those that have already taken steps to align clinically or financially through arrangements such as an IPA or clinically-integrated network (CIN). We urge CMS to allow group practices that are part of an IPA or CIN or working with a management company to leverage those existing relationships in forming a virtual group.

The Association is also concerned the prohibition against changing a virtual group election during the performance period will harm the virtual group’s ability to ensure collective performance. One of the primary levers business partners use to achieve the desired outcome of an agreement is a defined end of the relationship when one of the parties is not meeting the terms of the arrangement. Especially at the dawn of this new concept, when data about other groups’ and clinicians’ past quality performance will be virtually null and thus there will be greater risk in forming a virtual group, these parties should not be constrained from including terms defining the end of the relationship in circumstances, such as when a party to the network refuses to perform the agreed-to measurement activities. If a member of the virtual group is not contributing as expected, the network should be able to cut ties with that individual or group according to the terms of their virtual group agreement.

Finally, MGMA is concerned that the lack of a framework for virtual groups has the potential to create significant confusion and uncertainty about the interaction between this concept and the federal self-referral and antikickback laws, as well as anti-trust rules. We seek clarification from CMS about the program integrity alignment of virtual groups and encourage the agency to immediately release detailed information about the implications of forming a virtual group on the Federal Self-Referral (Stark) Law, federal anti-kickback rules, and federal antitrust rules. This way, stakeholders may maintain safeguards against fraud and abuse while soliciting partners for the virtual group network and working toward common MIPS goals.

MIPS quality performance category

Reporting requirements

CMS proposal (82 Fed. Reg. 30038): CMS does not propose to change its policy that ECs and group practices generally report data on six quality measures, including at least one outcome measure (or high-priority measure if no outcome measure is available), or one specialty measure set. CMS would continue to measure the all-cause hospital readmission rate for groups with 16 or more ECs who meet the 200-case minimum. CMS proposes to remove two Summary Survey Measures from the CAHPS for MIPS patient satisfaction survey and seeks input about adding open-ended narrative reviews of clinicians and groups.

MGMA comment: MGMA supports CMS’ proposal not to increase the number of required quality measures and continues to advise the agency to further reduce the reporting burden in this category by decreasing the reporting requirement and allowing ECs and group practices to report additional quality measures at their discretion. MGMA regularly hears from physician group practices that it is challenging to identify six clinically-relevant measures, even within the specialty measure sets. Rather than requiring practices to split their focus among measures that may not be as relevant to their patient population and clinical specialty, reducing the reporting requirements would allow practices to prioritize their energy and resources on a few meaningful measures that, if performed well, could

move the dial on improving care and reducing costs.

MGMA opposes CMS' proposal to continue to measure group practices with 16 or more ECs and who meet the case minimum on the all-cause hospital readmission measure. As the agency has done in the cost category, CMS should retire the flawed Value-Based Payment Modifier (VBPM) population health measures. These measures were developed to evaluate outcomes at the community level with 100,000 patients and have very low statistical reliability at the individual clinician and group practice levels. Additionally, because these measures rely on the flawed VBPM patient attribution methodology, they often hold practices and providers accountable for the outcomes of care they had very little influence over, particularly for specialty and rural practices. CMS must take this opportunity to address the myriad of problems identified in the previous programs, including the lack of clinically relevant measures for the vast majority of practices and specialties, and eliminate them from the quality performance category. Rather, CMS should make them optional in the improvement activities category, at least until these underlying problems can be studied and addressed.

Finally, although we understand the importance of adding open-ended narrative reviews of clinicians and groups to the patient satisfaction survey for quality improvement, we are concerned about adding these narratives to the standardized CAHPS for MIPS survey that will be used to adjust physician payment and potentially included on the Physician Compare website, which has been plagued by inaccuracies and considerable delays in updating essential information. Inaccuracies are frustrating for practices that must deal with both the administrative hassles of correcting misinformation and addressing any undue harm to their reputation. Adding open-ended narrative reviews, uncoupled from an ability of the group practice to respond in a timely fashion, could erroneously and unfairly damage a group's reputation. We further urge CMS to conduct an extensive analysis of the influence of open-ended narratives, which may reflect circumstances outside the control of the clinician. If the agency moves forward, it must, at a minimum, establish a process for screening libelous or slanderous comments and create a simple appeals process that allows physicians and group practices to challenge unfair or inaccurate narratives before they are publicized.

Data completeness criteria

CMS proposal (82 Fed. Reg. 30041): CMS proposes to maintain a data completeness threshold of 50% of all patients when reporting via registry, quality clinical data registry (QCDR) and EHR, and 50% of Medicare patients for claims-based reporting. For the 2019 performance year, CMS proposes to increase the threshold to 60% and anticipates increasing it further in subsequent years.

MGMA comment: MGMA commends CMS for maintaining a data completeness threshold of 50% for the 2018 performance period. However, we strongly oppose an increase in the threshold to 60% in the 2019 performance year, as it reduces any wiggle room a group practice may need to make technological infrastructure changes or address any system interruptions or other administrative factors that often fall outside the control of the physician or practice. CMS itself states the proposal is intended to "reduce burden and accommodate operational issues that may arise during data collection during the initial years of the program" (82 Fed. Reg. 30041). Moreover, expanding most reporting mechanisms to all-payer data inherently increases the amount of data the agency receives, calling into question any need to increase the threshold. We urge CMS to retain a data completeness threshold of 50% in both 2018 and 2019 to instill stability and to seek stakeholder feedback regarding any increase in the threshold only when program data show a large majority of group practices are meeting existing data completeness requirements.

“Topped out” measures

CMS proposal (85 FR 30045): CMS proposes to cap a subset of six “topped out” measures at six points. Through future rulemaking, the agency would remove measures from the MIPS measures list after being topped out for three consecutive years. CMS considers a measure topped out if performance is so high and unvarying that meaningful distinctions and improvement in performance cannot be made. Based on 2015 PQRS data, CMS identified approximately 45% of quality measures as topped out, including 70% of claims measures, 10% of EHR measures, and 45% of registry and QCDR measures. CMS also seeks comment regarding the best timeline for removing both non-outcome and outcome measures that cannot be reliably scored against a benchmark for three years.

MGMA comment: MGMA opposes CMS’ proposal to cap “topped out” measures at six points. Adding another layer of complexity to the MIPS scoring system is inconsistent with the overarching priority of this proposed rule to reduce administrative burden and simplify the program. We also take issue with the belief that the quality reporting programs have reached the tipping point where physicians and group practices are selecting “topped out” measures that are easy to report. Further, the decile-based benchmark system already discourages physicians from reporting “topped out” measures. In many instances, performance on a “topped out” measure at any rate less than perfect – even 99.99% – earns just 7 or 8 points. In one particularly illustrative example, a 99.99% performance rate on measure 117, “Diabetes: Eye Exam,” earns just 4 points when reported via claims and 6 points when reported via registry/QCDR.

While we appreciate CMS’ proposal to remove measures only after three years of being deemed “topped out” to prevent against random fluctuations in reporting resulting in removal, MGMA is alarmed this would result in removal of nearly half of all quality measures in 2019, including 70% of claims measures, 10% of EHR measures, and 45% of registry and QCDR measures. We hear regularly from members that they continue to see gaps in the current measure set and, as a result, struggle to select and report clinically relevant quality measures. Removing nearly half of all quality measures will only exacerbate this problem. Assuming the agency’s goal is to measure clinicians and groups on a core set of quality metrics, we believe retiring more than 100 measures in a single year would be premature and disruptive. Neither the health care industry nor CMS have reached consensus around a set of core quality measures.

Rather than chopping the measure list in half, CMS should take a more deliberate approach, ensuring the “topped out” measures proposed for removal do not disproportionately impact one reporting mechanism or specialty. We encourage CMS to defer to measure developers and national endorsement bodies regarding which measures are “topped out” as a result of being easy to report versus those that are “topped out” because the desired outcome has become so commonplace as to warrant the retirement of the quality measure.

Finally, if CMS moves forward with its proposal, the agency must engage in a comprehensive education and outreach campaign to provide sufficient notice to physician group practices. In addition to labeling “topped out” measures in all measure appearances, including on the QPP website and in the benchmark spreadsheet, CMS should notify physicians and groups in their feedback reports about whether any of the measures they submitted have been deemed “topped out.” We urge CMS to work with data submission vendors to provide feedback to group practices that select “topped out” measures and to provide feedback in the remittance advice to clinicians who submit data about a “topped out” measure via claims.

Floor for scored quality measures

CMS proposal (82 Fed. Reg. 30042, 30102, 30106): ECs and groups who submit quality measures that can be scored against a benchmark and meet the data completeness criteria and case minimum requirements would receive between three and 10 points. However, CMS proposes to reduce the quality scoring measure floor from three points to one point for all quality measures submitted without meeting the data completeness threshold. For small practices, CMS would continue to apply a floor of three points, regardless of whether the data submitted meets the data completeness thresholds. ECs and groups who submit measures without meeting the case minimum requirements or without an applicable benchmark would continue to receive three points.

MGMA comment: MGMA supports a global minimum floor score for quality measures and urges CMS to continue the current policy instituting a global minimum floor of three points for all clinicians and group practices through at least the 2018 performance period. Under program guidelines, group practices and ECs will not receive feedback regarding their performance in the 2017 transition year until partway through the 2018 performance period. Many groups and physicians will only learn whether they met the case minimum or data completeness thresholds through these feedback reports, and, by that time, it would be too late to adjust their reporting strategy for the 2018 performance period. Therefore, to ensure group practices and ECs have sufficient opportunity to incorporate feedback and improve quality measure performance, CMS should maintain the global minimum floor through at least the 2018 performance period. We cannot reiterate enough how important it is that the requirements for this category are achievable at the outset, as it will count for a majority of the MIPS score.

Incentives to use CEHRT in the quality performance category

CMS proposal (82 Fed. Reg. 30109): CMS seeks comment on the use of health IT in quality measurement and how the U.S. Department of Health and Human Services (HHS) can encourage the use of certified EHR technology in quality measurement.

MGMA comment: In addition to earning bonus points in the quality performance category, MGMA believes physicians and practices submitting quality measures via end-to-end electronic reporting should also earn full credit towards their ACI score. ECs use CEHRT and other tools that leverage interoperable standards for data capture, usage, and exchange to facilitate and enhance patient and family engagement, care coordination among diverse care team members, and, in continuous learning and rapid-cycle improvement leveraging advanced quality measurement and safety initiatives. CMS should recognize that if a physician or practice is leveraging CEHRT to report quality measures, they are also demonstrating they are using the technology to capture, document, and communicate patient care information and should therefore receive both quality and ACI credit.

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

Measuring and scoring improvement

CMS proposal (82 Fed. Reg. 30113): CMS proposes to measure improvement by comparing achievement in the current performance period against historic achievement. The agency would measure improvement at the category level, as opposed to the individual measure level, to account for annual measure changes. CMS would add up to 10 points to an EC's or group's final quality score to reflect year-to-year improvement. CMS would only score improvement above 30 percentage points, which is equivalent to submitting six measures and earning the baseline three points per measure. CMS would only calculate an improvement score for ECs and groups that meet all the quality measure submission requirements, including data completeness.

When there is no previous score for the same identifier, CMS would identify a comparable score for individual submissions by taking the highest score associated with the clinician's TIN or NPI. For a group, CMS would calculate an average of individual scores associated with the group's TIN.

MGMA comment: While MGMA supports CMS' proposal to ensure improvement points are positive and cannot be lower than zero, we are concerned it is premature to measure improvement in MIPS. One significant barrier to measuring improvement is the 18-month lag between performance and feedback. Group practices operate in a fluid environment of recruitment, acquisition, expansion, and reduction. Even if the group composition remains identical between performance years, CMS would not advise how the group can improve for up to 18 months—a gap that does not allow adequate time to implement actionable changes to drive improvements. Abundant education and outreach regarding improvement scoring is paramount to the success of the program, so that groups and providers know exactly what standards they are expected to achieve. We urge CMS to wait until it has reviewed and analyzed the first few years of MIPS performance data to understand and target areas for improvement. Further, we strongly encourage CMS to test each of the proposed methodologies in the physician practice environment before introducing them in MIPS.

MIPS cost performance category

Cost measures and weighting

CMS proposal (82 Fed. Reg. 30048): CMS proposes to reweight the cost component of MIPS to zero in the 2018 performance period and expects to increase its weight to 30% in 2019 and beyond, as required by statute. Although the cost category would not count toward an EC's or group's MIPS score, CMS would continue to calculate the total per capita cost and Medicare Spending Per Beneficiary (MSPB) measures using administrative claims data. CMS is not proposing to include the 10 episode-based measures that the agency adopted for the 2017 performance period. Instead, CMS plans to “develop new episode-based measures with significant clinician input, for future performance periods.” CMS intends to provide feedback to applicable clinicians and groups beginning in the fall.

MGMA comment: MGMA supports CMS' proposal to use the Secretary's authority under section 1848(q)(5)(F) of MACRA to reweight the cost performance category to zero. There are ongoing methodological barriers to measuring resource utilization. Namely, CMS needs to better identify and adjust for the cost of treating high-risk patients and must identify a more accurate way to apportion costs than holding a single physician responsible for the total annual cost of treating a particular patient. Recommendations for improving the cost component of MIPS include using more detailed specialty designations and recognizing sites of service and regional variations. Additionally, cost measures should be centered around specific conditions or periods of care.

CMS should continue to weigh this category at zero until the agency has extensively tested the new episode-based measures, reformed and fully tested the patient attribution methodology, and implemented risk- and specialty-adjustment recommendations from the congressionally-mandated report by the ASPE. Further, it is critical that the agency provide timely and actionable information regarding these measures, which further supports delaying measurement of clinicians and groups on cost groups until it is operationally feasible to provide cost and attribution feedback on at least a quarterly basis.

Cost measure reliability

CMS proposal (82 Fed. Reg. 30050): CMS proposes to retain a reliability threshold of 0.4.

MGMA comment: MGMA urges CMS to increase the reliability threshold. CMS admits 0.4 reliability is on the low end of the reliability spectrum. “We generally consider reliability levels between 0.4 and 0.7 to indicate “moderate” reliability and levels above 0.7 to indicate “high” reliability” (82 Fed. Reg. 30050). “High reliability for a measure suggests that comparisons of relative performance among clinicians are likely to be stable over different performance periods and that the performance of one clinician on the measure can be confidently distinguished from another” (82 Fed. Reg. 30050). CMS justifies low reliability as a tradeoff for higher variation among clinicians and groups. “Placing too much of an emphasis on reliability calculations could limit the applicability of cost measures to large group practices who, by nature of their size, have larger patient populations, thus depriving solo clinicians and individual reporters from being rewarded for efforts to better manage patients” (82 Fed. Reg. 30051). Although these may be tradeoffs the agency is willing to make as it scores achievement, it seems unreasonable to maintain low reliability while simultaneously measuring improvement. How can any physician or group practice be sure CMS is truly measuring improvement with only a 0.4 reliability threshold?

MIPS improvement activities (IAs) performance category

IA reporting criteria

CMS proposal (82 Fed. Reg. 30053): To achieve the highest potential score, ECs and groups generally must attest to or report on completion of two high-weighted IAs or four medium-weighted IAs, or some combination of the two, for a minimum of 90 continuous days. ECs and groups may submit IA data using a qualified registry, EHR, QCDR, CMS Web Interface or attestation. CMS proposes small groups (consisting of 15 or fewer ECs) and ECs and groups in rural areas or health professional shortage areas would receive full credit for reporting any two IAs (either high- or medium-weighted). ECs and groups participating in an APM would automatically receive 50% of the total IA score. Finally, the agency proposes to expand and rename its “CMS Study on Improvement Activities and Measurement” to “CMS study on burdens associated with reporting quality measures.”

MGMA comment: MGMA supports the proposal to retain the maximum number of required activities. Instilling consistency year-to-year allows practices to focus on quality improvement rather than having to relearn and implement new program rules every calendar year. We also agree that a yes/no attestation is a flexible and simple mechanism for reporting these activities, and we support transmission of activities through registries, EHR vendors, and QCDRs where feasible. MGMA also supports CMS’ proposal to allow small, rural, and non-patient facing practices to earn full credit for performing any two activities.

The Association is disappointed CMS did not propose to award full IA credit to APM participants. MGMA urges CMS to award full IA credit for participation in an APM, as success in risk-based payment models requires practices to work towards a significant number of clinical improvement initiatives that align with MIPS IA inventory in order to shift their focus from volume to value. Additionally, we believe the statute affords CMS the flexibility to grant full IA credit, as section 1848(q)(5)(C)(ii) of MACRA provides that participants in an APM must earn *at least* one half of the highest potential score for the IA performance category (emphasis added). Therefore, CMS is well within the bounds of the law to award more credit, and MGMA believes CMS should award full credit for groups and physicians that are participating in an APM. Further, the definition of an APM under MIPS should not be limited to Advanced or MIPS APMs, but should incorporate participation in any APM, including those sponsored by a commercial payer, state government agency, or Medicaid. At a minimum, MGMA urges CMS to codify its decision to award full IA credit to the existing MIPS APMs as outlined in CMS' subregulatory document entitled, "Scores for Improvement Activities in MIPS APMs in the 2017 Performance Period." This would promote stability, allowing participants to prioritize the aims of the APM, and prevent participants from having to adjust their IA strategy annually.

We appreciate CMS' efforts to study the challenges and costs of reporting quality measures by expanding and aptly renaming the "CMS study on burdens associated with reporting quality measures." We encourage the agency to make public the results of the survey, which CMS expects will inform "the root causes of clinicians' performance measure data collection and data submission burdens and challenges that hinders accurate and timely quality measurement activities."

Group reporting of IAs

CMS proposal (82 Fed. Reg. 30053): In the CY 2017 QPP final rule, CMS clarified that if one MIPS EC in a group completed an IA, the entire group would receive credit for that activity. CMS seeks comment on whether the agency should establish a minimum threshold (for example, 50 percent) of clinicians that must complete an IA for the entire group to receive IA credit in future years.

MGMA comment: MGMA opposes an arbitrary threshold for groups reporting IAs collectively. While a very small number of activities may be attributed to individual clinicians within the group practice, we believe when reporting as a group practice, it would be challenging to apportion a significant number of the IAs and even more difficult to determine and document whether 50% or more of the ECs in a group completed the activity. For instance, a group practice who is attesting to completion of Activity IA_PSPA_17, "Implementation of analytic capabilities to manage total cost of care for practice population," may have assigned the responsibility of investigating and implementing the technology and analytic functions to non-clinical staff, who may also monitor and disseminate the resulting data to clinicians. How could a group practice, which is collectively prioritizing this data collection and analysis, attest to meeting a 50% threshold?

IA credit for patient-centered medical homes (PCMHs)

CMS proposal (82 Fed. Reg. 30054): CMS proposes to change the policy for awarding full credit as a certified or recognized PCMH or comparable specialty home, and would require at least 50% of the practice sites within the TIN to be recognized as a PCMH or comparable specialty practice. This is an increase to the requirement that only one practice site within a TIN needs to qualify in order for the entire TIN to receive credit. CMS would also award full IA credit to group practices participating in the control group portion of the Comprehensive Primary Care Plus (CPC+) model.

MGMA comment: Similar to the proposed threshold for group reporting IAs, we believe a practice site threshold for PCMHs to earn IA credit is arbitrary and untenable. Group practices that earn recognition as a PCMH have demonstrated a commitment to transforming their delivery of care in a way that prioritizes care coordination and patient-centered outcomes. Whether the group has established a single practice location, integrating all services under one roof, or set up multiple locations to improve patient access, the core functions of the PCMH permeate the entire group practice. For instance, the use of a clinical data registry to inform all group physicians, regardless of location, about the patient's health status and the ability of a care navigator would benefit the entire group practice – regardless of the practice address. Further, we believe this policy could create unintended consequences. Imagine a scenario in which a group practice has three locations, and one is certified as a PCMH. Under a 50% threshold, would the group receive zero recognition for the effort and resources devoted to providing patient-centered care through a medical home? We urge CMS to recognize the benefits of attaining and maintaining medical home certification by awarding full IA credit to all group practices who have at least one practice site recognized as a PCMH or comparable specialty home.

Additionally, although we believe these group practices should have been eligible for full participation in the CPC+ alternative payment model, MGMA supports CMS' proposal to recognize the efforts of physician practices who qualified for participation in CPC+ but were randomly routed into the control group of the model by awarding full IA credit to these groups. We encourage CMS to make this an automatic process to eliminate any administrative burden on these groups.

Measuring achievement and improvement in IAs

CMS proposal (82 Fed. Reg. 30053): CMS seeks feedback about measuring performance and improvement in the IA performance category.

MGMA comment: MGMA strongly opposes measuring IAs on achievement and improvement. We believe the congressional intent in MACRA was to recognize clinicians and group practices for ongoing efforts to improve patient care, rather than create another onerous Medicare reporting requirement. Additionally, it would be excessively challenging to define and measure achievement and improvement in many of IAs. For instance, CMS could consider instituting a minimum number of hours devoted to a certain activity in order to receive credit, but then would risk incentivizing minimal performance for a longer period of time instead of continued progress. We urge CMS to continue to base IA credit on completion or ongoing participation.

IA inventory

CMS proposal (82 Fed. Reg. 30055): CMS proposes to formalize an Annual Call for Activities process for adding new activities to the IA Inventory beginning in the 2019 performance period. "Individual MIPS eligible clinicians and groups and relevant stakeholders would be able to provide an explanation via the nomination form of how the improvement activity meets all the criteria."

MGMA comment: MGMA appreciates CMS' efforts to develop a formal process through which the agency will add new activities each year as technology advances and practices find new and innovative ways to improve patient care. We urge CMS to accept a broad set of activities so as not to create another clinically meaningless reporting process. Additionally, we have heard from medical specialty societies that CMS has not provided any feedback regarding improvement activities that were submitted but not added to the inventory. We urge the agency to provide timely, comprehensive feedback regarding its rationale for not including a proffered activity in the inventory, so that the submitter may reconcile any outstanding issues and resubmit the activity.

MGMA also recommends CMS accept comments regarding the weighting of activities already included in the IA inventory. There are numerous resource-intensive and high-quality activities that are listed as only medium weight. We advise the agency to seek stakeholder feedback from the appropriate medical specialties to reevaluate whether the appropriate weight was assigned to each IA when factoring in considerations such as time commitment, effort and patient benefit.

MIPS ACI performance category

ACI Base Score

CMS proposal (82 Fed. Reg. 30058, 30071): “For the CY 2018 performance period, we are not proposing any changes to the base score methodology as established in the CY 2017 Quality Payment Program final rule (81 FR 77217–77223). We established the policy that MIPS eligible clinicians must report a numerator of at least one for the numerator/denominator measures, or a “yes” response for the yes/no measure in order to earn the 50 percentage points in the base score. In addition, if the base score requirements are not met, a MIPS eligible clinician would receive a score of zero for the ACI performance category.”

MGMA comment: We contend that requiring four objectives for the ACI base score (Security Risk Analysis, Provide Patient Access, ePrescribing, and Health Information Exchange) adds an unnecessary burden for ECs and groups participating in MIPS. The Security Risk Analysis has been required by law since the HIPAA Security final rule was implemented in 2005 and the remaining three objectives are fundamental functions of 2014 Edition and 2015 Edition CEHRT. Should an EC or group attest to implementing 2014 Edition CEHRT, 2015 Edition CEHRT or a combination of the two Editions, they should be deemed to have met the ACI base score and be awarded 50% of the total ACI score. Removing the administrative requirements associated with meeting superfluous base score objectives would be a further incentive for physician practices to adopt CEHRT

Security Risk Assessment

CMS proposal (82 Fed. Reg. 30068): “Objective: Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards. Security Risk Analysis Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by CEHRT in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the MIPS eligible clinician’s risk management process.”

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

The HIPAA security regulation outlines the process an organization must go through, but does not specify the exact steps, milestones or expected outcomes of that analysis. Consequently, compliance with this requirement and fulfillment of this current and proposed ACI requirement has proven

difficult, especially for smaller practices that typically have limited in-house expertise in this area. CMS should work with the Office for Civil Rights (OCR) to develop guidance and education on the issues of risk analysis and mitigation. In particular, we would encourage full transparency from those agencies that conduct audits of practice security processes and procedures. Having CMS (through Figliozzi), OCR, and the Office of Inspector General provide comprehensive details of each of its audit processes and de-identified findings is essential for practices to understand the government's risk analysis requirements and expectations.

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

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

Health Information Exchange Measure

CMS proposal (82 Fed. Reg. 30067): "For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care clinician (1) creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record."

MGMA comment: As we outlined above in our comment on the base score, requiring an EC or group to report for at least one transition of care or referral the Health Information Exchange measure in order to meet a base score objective simply adds additional tasks for minimal value. The agency should seek to identify every opportunity to eliminate redundancy and administrative burdens associated with participation in the QPP. Again, by simply investing in 2014 Edition CEHRT, 2015 Edition CEHRT, or a combination of the two, the physician practice has provided sufficient evidence that they are leveraging this technology to deliver patient care.

Should the objective continue to be required, MGMA also has concerns regarding what would constitute an acceptable "electronic" transmission related to an exchange of health information. Recognizing that each transmission method may require the practice to reconfigure workflows, we recommend CMS develop clear guidance to assist ECs in clearly understanding transmission options at the onset of the performance period. Additionally, we concur with the agency's earlier contention that opening up the measure for alternative electronic delivery pathways could reduce administrative expense for ECs seeking to meet this measure, though we do not believe this flexibility will completely eliminate EC costs. We urge the agency to monitor ongoing EC transmission costs and burdens and modify this measure should the evidence suggest ECs are being subjected to overly expensive or burdensome processes.

Measure Exclusions

CMS proposal (82 Fed. Reg. 30073-30074): "We are proposing to add exclusions to the measures associated with the Health Information Exchange and Electronic Prescribing objectives required for the

base score. In the CY 2017 Quality Payment Program final rule (81 FR 28237 through 28238), we established a policy that MIPS eligible clinicians who write fewer than 100 permissible prescriptions in a performance period may elect to report their numerator and denominator (if they have at least one permissible prescription for the numerator), or they may report a null value. This policy has confused MIPS eligible clinicians as a null value would appear to indicate a MIPS eligible clinician has failed the measure and thus not would not achieve a base score. We are proposing to change this policy beginning with the CY 2017 performance period and propose to establish an exclusion for the e-Prescribing Measure. MIPS eligible clinicians who wish to claim this exclusion would select “yes” to the exclusion and submit a null value for the measure, thereby fulfilling the requirement to report this measure as part of the base score. It is important that a MIPS eligible clinician actually claims the exclusion if they wish to exclude the measure. If a MIPS eligible clinician does not claim the exclusion, they would fail the measure and not earn a base score or any score in the advancing care information performance category.

Proposed Exclusion: Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period.”

MGMA comment: ECs and groups may not be able to receive any credit for ACI because they are unable to fulfill the measures associated with the Health Information Exchange or ePrescribing objectives in the base score. These ECs and groups seldom or never refer or transition patients and therefore may not be able to meet even the one patient threshold for this measure. Similarly, ECs or group that infrequently or never write prescriptions in their practice or lack prescribing authority may not be able to meet the ePrescribing objective and would therefore also fail to earn any ACI score and would lose the entire 25 ACI points. We are therefore fully supportive of establishing exclusions for these measures. CMS should, however, raise the exclusion thresholds to more accurately reflect physician practice operations. We would urge the Health Information Exchange threshold to be increased from fewer than 100 transitions of care or referrals during the performance period to fewer than 200 transitions of care or referrals. For the ePrescribing Measure, we recommend that the threshold be increased from fewer than 100 permissible prescriptions in a performance period to fewer than 200 permissible prescriptions.

Performance score

CMS proposal (82 Fed. Reg. 30066): “We are proposing to maintain for the CY 2018 performance period the Advancing Care Information Objectives and Measures as finalized in the CY 2017 Quality Payment Program final rule (81 FR 77227 through 77229) with the modifications proposed below.”

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

As an example of what a fictitious EC’s performance score might look like, recording a high score in a category that is within the EC’s control (i.e., 95% for providing “patient access”) is far more

achievable than recording a similar score for categories that require third party action (i.e., secure messaging). It is telling that in the final modification rule for the Medicare and Medicaid EHR Incentive Program, published Oct. 6, 2015, the agency lowered the original Stage 2 requirements for the view, download, transfer and secure messaging objectives from 5% to one patient, and having the capability, respectively, because many clinicians experienced substantial challenges in meeting these and other measures requiring third party action. We do not believe the healthcare environment has changed significantly since the release of the modification rule to expect ECs and groups to achieve high scores in categories that require patient action.

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

CMS proposal (82 Fed. Reg. 30067): “We propose if a MIPS eligible clinician fulfills the Immunization Registry Reporting Measure, the MIPS eligible clinician would earn 10 percentage points in the performance score. If a MIPS eligible clinician cannot fulfill the Immunization Registry Reporting Measure, we are proposing that the MIPS eligible clinician could earn 5 percentage points in the performance score for each public health agency or clinical data registry to which the clinician reports for the following measures, up to a maximum of 10 percentage points: Syndromic Surveillance Reporting; Electronic Case Reporting; Public Health Registry Reporting; and Clinical Data Registry Reporting. A MIPS eligible clinician who chooses to report to more than one public health agency or clinical data registry may receive credit in the performance score for the submission to more than one agency or registry; however, the MIPS eligible clinician would not earn more than a total of 10 percentage points for such reporting.

We further propose similar flexibility for MIPS eligible clinicians who choose to report the measures specified for the Public Health Reporting Objective of the 2018 Advancing Care Information Transition Objective and Measure set. We propose if a MIPS eligible clinician fulfills the Immunization Registry Reporting Measure, the MIPS eligible clinician would earn 10 percentage points in the performance score. If a MIPS eligible clinician cannot fulfill the Immunization Registry Reporting Measure, we are proposing that the MIPS eligible clinician could earn 5 percentage points in the performance score for each public health agency or specialized registry to which the clinician reports for the following measures, up to a maximum of 10 percentage points: Syndromic Surveillance Reporting; Specialized Registry Reporting. A MIPS eligible clinician who chooses to report to more than one specialized registry or public health agency to submit syndromic surveillance data may earn 5 percentage points in the performance score for reporting to each one, up to a maximum of 10 percentage points.”

MGMA comment: We support this proposal and concur that by proposing to expand options for fulfilling the Public Health Reporting objective, the agency is adding much needed flexibility so that additional MIPS ECs can successfully meet this objective and earn 10 percentage points in the performance score. However, we oppose the proposed “two-for-one” requirement that requires an EC to successfully report two alternate public health agencies and/or registries for a points value of only 5 points for each. Due to the level of complexity and resource investment commonly associated with

linking to and enabling reporting to public health agencies and/or registries, reporting to one other public health agency or registry should suffice. We recommend modifying this proposal to permit reporting to one alternate public health agency or registry to satisfy the requirements for immunization registry reporting.

View, Download or Transmit (VDT) and Secure Messaging objectives

CMS proposal (82 Fed. Reg. 30068): “The performance period, at least one unique patient (or patient authorized representatives) seen by the MIPS eligible clinician actively engages with the EHR made accessible by the MIPS eligible clinician by either (1) viewing, downloading or transmitting to a third party their health information; or (2) accessing their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the MIPS eligible clinician’s CEHRT; or (3) a combination of (1) and (2). We are proposing this change because we erroneously described the actions in the measure (viewing, downloading or transmitting; or accessing through an API) as being taken by the MIPS eligible clinician rather than the patient or the patient-authorized representatives. This change would align the measure description with the requirements of the numerator and denominator. We propose this change would apply beginning with the performance period in 2017. • Denominator: Number of unique patients seen by the MIPS eligible clinician during the performance period. • Numerator: The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient’s health information during the performance period and the number of unique patients (or their authorized representatives) in the denominator who have accessed their health information through the use of an API during the performance period.

Secure Messaging Measure: For at least one unique patient seen by the MIPS eligible clinician during the performance period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient’s representative).”

MGMA comment: It is important to note that MGMA members have reported experiencing significant challenges in having patients access their clinical records using practice-supplied web portals for VDT and secure messaging. Not only are there technical hurdles to overcome before the practice can deploy a patient portal that is both convenient for the patient and securely protects data, but an overwhelming percentage of patients never take advantage of VDT or secure messaging clinical functionalities. However, a larger percentage leverage these web-based services for administrative tasks.

Many relationships between certain medical specialties and clinics and their patients may not necessitate access to the medical record or benefit from electronic messaging through a web portal. Following what could be a short consultation with the EC, it could prove highly unlikely the patient would subsequently create an account and log into a portal to view, download, or transmit their medical record or send a secure message. Further, with ECs and group practices providing the patient with a summary of the visit, it makes it unlikely the patient would leverage a web portal to access what could be the exact same information. In addition, the recently revised HIPAA Privacy regulations already require providers make available to the patient their record in an electronic format, rendering this particular requirement not only unrealistic, but redundant.

While we may agree that as technology improves, patients are likely to become more engaged in their healthcare, the industry is clearly not at the stage where high percentages of patients engage their clinicians via these web services, particularly those in the Medicare population. At the same time, more and more patients want to leverage online functionalities when interacting with the healthcare system.

Our members, however, report that patients are far more interested in utilizing other online administrative tools directly via a web portal or through use of secure messaging, such as appointment scheduling, prescription refill requests, reviewing and paying outstanding balances, completion of registration information, the HIPAA acknowledgement of receipt of the practice's Notice of Privacy Practices, insurance-related information, and other required forms. We strongly recommend these administrative transactions be permitted to count toward the VDT and secure messaging numerators, including those that occurred prior to, or in lieu of, a face-to-face visit with the EC. By incentivizing and rewarding practices for encouraging patients to use this wider variety of online administrative services, it would be much easier to simultaneously encourage patients to also view, download or transmit their record or access secure messaging, thereby achieving higher levels of patient digital involvement.

Bonus Score

CMS proposal (82 Fed. Reg. p. 30058): “We are proposing to modify our policy beginning with the performance period in CY 2018. We are proposing that a MIPS eligible clinician may only earn the bonus score of 5 percentage points for reporting to at least one additional public health agency or clinical data registry that is different from the agency/agencies or registry/or registries to which the MIPS eligible clinician reports to earn a performance score. For example, if a MIPS eligible clinician reports to a public health agency and a clinical data registry for the performance score, they could earn the bonus score of 5 percentage points by reporting to a different agency or registry that the clinician did not identify for purposes of the performance score. A MIPS eligible clinician would not receive credit under both the performance score and bonus score for reporting to the same agency or registry. We are proposing that for the Advancing Care Information Objectives and Measures, a bonus of 5 percentage points would be awarded if the MIPS eligible clinician reports “yes” for any one of the following measures associated with the Public Health and Clinical Data Registry Reporting objective: Syndromic Surveillance Reporting; Electronic Case Reporting; Public Health Registry Reporting; or Clinical Data Registry Reporting.”

MGMA comment: We fully support the proposal that, for the 2018 ACI transition objectives and measures, a bonus of 5 percent would be awarded if the EC or group reports “yes” for following measures associated with the Public Health Reporting objective: Syndromic Surveillance Reporting or Specialized Registry Reporting. We also agree that to earn the bonus score, the EC or group must be in active engagement with one or more additional public health agencies or clinical data registries that is/are different from the agency or registry that they identified to earn a performance score. The definition of “active engagement” should mirror that established under the Meaningful Use EHR Incentive Program-registered to participate with the public health entity, planning on submitting data to a public health entity, or actively submitting data to a public health entity.

Certified EHR Technology Requirements

CMS proposal (82 Fed. Reg. 30064): “That estimate is that 74 percent of MIPS eligible clinicians will be ready to participate in MIPS using 2015 Edition certified EHR technologies by January 1, 2018. However, subsequent to the preliminary analysis, ONC has continued to monitor readiness and to receive feedback from stakeholders on factors influencing variations in the development and implementation timelines for developers supporting different segments of the market, as well as the relationship between the developer readiness timeline and participant readiness. This continuing analysis supports a potential need for a longer implementation timeline for MIPS eligible clinicians... We continue to believe that there are many benefits for switching to EHR technology certified to the 2015 Edition... However, in light of the conservative readiness estimates for MIPS

eligible clinicians, and in line with our commitment to supporting small practices, solo practitioners and specialties which may be more likely to use certified health IT offered by small developers, we are proposing that MIPS eligible clinicians may use EHR technology certified to either the 2014 or 2015 Edition certification criteria, or a combination of the two for the CY 2018 performance period.”

MGMA comment: While we appreciate the earlier optimism that the government has shown in its estimates of ECs adopting 2015 Edition CEHRT by January 2018, we contend that these estimates were flawed. Moving from 2014 Edition CEHRT to 2015 Edition CEHRT will be an onerous, costly, and challenging process for physician practices. EHR vendors are not required by law to recertify and MGMA remains extremely concerned that a significant percentage of the currently-certified products will not be recertified to the higher 2015 Edition standard, given the substantial costs associated with development, testing and rolling out to customers.

As of this writing, a review of the ONC listing of certified products shows that 3,750 products have been 2014 Edition certified. Contrasting this, only 96 products (24% which are offered from just 3 vendors) are certified as meeting the 2015 Edition requirements. Further, 181 software products are identified by ONC as being under a corrective action plan. Combined, this lack of vendor readiness and functionality suggests that mandating that ECs deploy 2015 Edition CEHRT in 2019 may be overly ambitious and therefore we recommend that program participants be given the option of continuing to use 2014 Edition CEHRT in 2019. At the same time, we urge CMS and ONC to closely evaluate the EHR vendor readiness in early 2018 to determine if it will have the capability to support ECs and groups meet this 2015 Edition CEHRT requirement by January 2019. Should it be determined that the vendor community is not yet ready to move ECs to 2015 Edition CEHRT, we would strongly recommend that extending the option for ECs and groups to use 2014 Edition CEHRT through the 2019 performance period be made as quickly as possible in 2018 to allow ECs and groups sufficient time to transition to new software, modify workflows and train staff.

Furthermore, even if vendors made 2015 Edition CEHRT available to their customers, the cost to practices purchasing new software and retraining staff would be significant. This would disproportionately impact smaller practices who are less likely to have the resources to purchase new EHR products in the first place, and if they do are more likely to purchase from smaller, more cost-effective vendors least likely to recertify to meet the 2015 requirements. The unintended result could be that the 2015 Edition CEHRT requirement acts as a disincentive for ECs from participating in the QPP. In order to streamline MIPS reporting requirements and decrease the administrative burdens associated with participation in the program, we recommend modifying the CEHRT requirements using the following approaches:

- ECs or groups attesting that that 2014 Edition CEHRT, 2015 Edition CEHRT, or a combination of the two are being used will be deemed to have met the ACI requirements and be awarded the full 25 points.
- Or, ECs or groups that attest to have successfully participated in one of more of the Improvement Activity options requiring the use of CEHRT will be deemed to have met the ACI requirements and be awarded the full 25 points.
- Or, ECs or groups that attest to have successfully participated reported quality measures using CEHRT will be deemed to have met the ACI requirements and be awarded the full 25 points.

Each of these approaches will better harmonize the various MIPS components and recognizes the EC or group’s use of CEHRT. By harmonizing these requirements, the administrative burden associated with capturing and reporting ACI-related data will be eliminated.

2015 Edition CEHRT bonus

CMS proposal (82 Fed. Reg. 30065): “We further note, that to encourage new participants to adopt certified health IT and to incentivize participants to upgrade their technology to 2015 Edition products which better support interoperability across the care continuum, we are proposing to offer a bonus of 10 percentage points under the advancing care information performance category for MIPS eligible clinicians who report the Advancing Care Information Objectives and Measures for the performance period in CY 2018 using only 2015 Edition CEHRT. We are proposing to amend §414.1380(b)(4)C(3) to reflect this change. We are proposing this one-time bonus for CY 2018 to support and recognize MIPS eligible clinicians and groups that invest in implementing certified EHR technology in their practice...Specifically, we seek comment on if the percentage of the bonus is appropriate, or whether it should be limited to new participants in MIPS and small practices. This bonus is not available to MIPS eligible clinicians who use a combination of the 2014 and 2015 Editions. We note that with the addition of the 2015 Edition CEHRT bonus of 10 percentage points, MIPS eligible clinicians would be able to earn a bonus score of up to 25 percentage points in CY 2018 under the advancing care information performance category, an increase from the 15 percentage point bonus score available in CY 2017. We invite comments on these proposals.”

MGMA comment: We support the inclusion of bonus points aimed at incentivizing ECs and groups to adopt 2015 Edition CEHRT. However, we encourage CMS to expand this bonus to include those ECs and groups who are using a combination of 2014 Edition and 2015 Edition CEHRT. In many cases, physician practices will transition from one software vendor’s product to another or one version of a software product to another during the calendar year. Expanding this bonus opportunity to those using a combination of 2014 Edition and 2015 Edition CEHRT would be a further incentive for practices to make this technology investment.

Additionally, transitioning to 2015 Edition CEHRT will require a significant financial and human capital investment and the bonus amount should reflect this investment. Due to this significant investment, we recommend that the bonus be increased from 10 points to 15. Alternatively, those ECs and groups using a combination of 2014 Edition and 2015 Edition CEHRT could receive a bonus of 10 points, with those ECs and groups using strictly 2015 Edition CEHRT receiving a bonus of 15 points. All bonuses for the use of 2015 Edition CEHRT should not be limited in terms of whether the EC is new to the QPP or limited in terms of group size. We contend that all ECs and all groups have access to this technology bonus.

Scoring Methodology Considerations

CMS proposal (82 Fed. Reg. 30065): “Section 1848(q)(5)(E)(i)(IV) of the Act states that 25 percent of the MIPS final score shall be based on performance for the advancing care information performance category. Further, section 1848(q)(5)(E)(ii) of the Act, provides that in any year in which the Secretary estimates that the proportion of eligible professionals (as defined in section 1848(o)(5) of the Act) who are meaningful EHR users (as determined under section 1848(o)(2) of the Act) is 75 percent or greater, the Secretary may reduce the applicable percentage weight of the advancing care information performance category in the MIPS final score, but not below 15 percent, and increase the weightings of the other performance categories such that the total percentage points of the increase equals the total percentage points of the reduction.”

MGMA comment: While the agency has the authority to reweight the ACI component of MIPS down from 25% to 15% of the total MIPS score once the proportion of ECs who are meaningful EHR users is 75% or greater, we would urge the agency to offer ECs and groups flexibility. Once the Secretary has

determined that the 75% threshold has been met, ECs and groups should be given the option of how their MIPS score should be weighted. Some ECs and groups may wish to continue having ACI comprise a full 25% of their total MIPS score, while others might prefer that their ACI score be weighted at 15%. Furthermore, we are concerned that if in future rulemaking CMS decides to propose changing the weight of the ACI performance category, such a change may cause confusion to ECs and groups who are adjusting to the MIPS program and believe this performance category will make up 25% of their total score.

Hardship exception for small practices

CMS proposal (82 Fed. Reg. 30076): “Significant Hardship Exception for MIPS Eligible Clinicians in Small Practices Section 1848(q)(2)(B)(iii) of the Act requires the Secretary to give consideration to the circumstances of small practices (consisting of 15 or fewer professionals) and practices located in rural areas and geographic HPSAs in establishing improvement activities under MIPS... We are proposing that this hardship exception would be available to MIPS eligible clinicians in small practices as defined under § 414.1305 (15 or fewer clinicians and solo practitioners)... We are proposing this exception would be available beginning with the 2018 performance period and 2020 MIPS payment year. We are proposing a MIPS eligible clinician seeking to qualify for this exception would submit an application in the form and manner specified by us by December 31st of the performance period or a later date specified by us. We are also proposing MIPS eligible clinicians seeking this exception must demonstrate in the application that there are overwhelming barriers that prevent the MIPS eligible clinician from complying with the requirements for the advancing care information performance category. In accordance with section 1848(a)(7)(B) of the Act, the exception would be subject to annual renewal. Under our proposal in section II.C.6.f.(7)(a), the 5-year limitation under section 1848(a)(7)(B) of the Act would not apply to this significant hardship exception for MIPS eligible clinicians in small practices.

We believe that applying the significant hardship exception in this way would be appropriate given the challenges small practices face as described by the commenters... While we would be making this significant hardship exception available to small practices in particular, we are considering whether other categories or types of clinicians might similarly require an exception. We solicit comment on what those categories or types are, why such an exception is required, and any data available to support the necessity of the exception. We note that supporting data would be particularly helpful to our consideration of whether any additional exceptions would be appropriate. We are seeking comments on these proposals.”

MGMA comment: MGMA is supportive of this consideration given to small practices. While physician practices of all sizes face challenges in selecting and implementing EHRs, smaller organizations in particular are less likely than larger organizations to have the resources and expertise necessary to adopt these technologies. Consequently, these smaller practices may be unable to successfully meet ACI requirements and would lose out on the full 25 points. By offering a hardship exception, the agency permits those smaller practices that do not have the requisite technology in place to be fully successful MIPS participants, but at the same time allows those smaller practices that have adopted 2014 Edition or 2015 Edition CEHRT to score points in the ACI category.

Hospital-Based MIPS ECs

CMS proposal (82 Fed. Reg. 30076): “...we defined a hospital-based MIPS eligible clinician under § 414.1305 as a MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the Place of Service (POS) codes used in the

HIPAA standard transaction as an inpatient hospital (POS 21), on-campus outpatient hospital (POS 22), or emergency room (POS 23) setting, based on claims for a period prior to the performance period as specified by CMS. We intend to use claims with dates of service between September 1 of the calendar year 2 years preceding the performance period through August 31 of the calendar year preceding the performance period, but in the event it is not operationally feasible to use claims from this time period, we will use a 12-month period as close as practicable to this time period...We would assign a zero percent weighting to the advancing care information performance category in the MIPS final score for a MIPS payment year for hospital-based MIPS eligible clinicians as previously defined. A hospital-based MIPS eligible clinician would have the option to report the advancing care information measures for the performance period for the MIPS payment year for which they are determined hospital-based.

Under the Medicare EHR Incentive Program an approved hardship exception exempted an EP from the payment adjustment. We believe that weighting the advancing care information performance category to zero percent is similar in effect to an exemption from the requirements of that performance category. We propose to amend § 414.1380(c)(1) and (2) of the regulation text to reflect this proposal.”

MGMA comment: We concur with defining a hospital-based EC as one who furnishes 75% or more of their covered services on site of service with POS codes 21, 22 and 23. We are also supportive of adding POS 19 to the definition of a “hospital-based EC.” Most importantly, we urge the agency to be transparent and give ECs timely notice well in advance of the start of the performance year whether or not they meet hospital-based status and therefore not required to participate in ACI. We have heard from members who report that practice ECs who were well above the threshold for the majority of the previous two years were unfairly penalized because the agency selected a seemingly arbitrary time period and the EC was consequently deemed under the 90% threshold.

We also concur with the agency’s determination that the 21st Century Cures Act grants the authority to the Secretary to apply the hospital-based exception from the Meaningful Use EHR Incentive Program to the QPP. It is clear that there are insufficient measures applicable and available to hospital-based ECs under the current proposals for the ACI performance category of MIPS. Hospital-based ECs typically do not have control over the decisions the hospital makes regarding the use of CEHRT. These ECs therefore may have no control over the type of CEHRT available, the way that the technology is implemented and used, or whether the hospital continually invests in the technology to ensure it is compliant with ONC certification criteria. In addition, some of the specific ACI performance category measures, such as the patient access measure under the patient electronic access objective, require that patients have access to view, download or transmit their health information from the EHR made available by the healthcare provider, which in this case would be the hospital. Therefore, the measure would be attributable and applicable to the hospital which controls the availability of the EHR technology, not the EC.

The requirement under the protect patient health information objective to conduct a security risk analysis would also force ECs to rely on the actions of the hospital, rather than those of the ECs themselves, as the hospital controls the access to and implementation of security policies and procedures. In this case, the measure is again more attributable and applicable to the hospital than to the MIPS EC.

ASC exception

CMS proposal (82 Fed. Reg. 30077): “To align with our hospital-based MIPS eligible clinician policy, we are proposing to define at § 414.1305 an ASC-based MIPS eligible clinician as a MIPS

eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the Place of Service (POS) code 24 used in the HIPAA standard transaction based on claims for a period prior to the performance period as specified by us... To determine a MIPS eligible clinician's ASC-based status, we are proposing to use claims with dates of service between September 1 of the calendar year 2 years preceding the performance period through August 31 of the calendar year preceding the performance period, but in the event it is not operationally feasible to use claims from this time period, we would use a 12-month period as close as practicable to this time period... For the 2019 MIPS payment year, we would not be able to notify MIPS eligible clinicians of their ASC-based status until after the final rule is published, which we anticipate would be later in 2017."

MGMA comment: For MIPS ECs who CMS determines are ASC-based, we support the proposal to assign a zero percent weight to the ACI performance category. We also support the proposed flexibility that would permit an ASC-based EC to voluntarily report for ACI and be scored based on performance. We also support the proposal that these ASC-based policies would apply beginning with the 2017 performance period/2019 MIPS payment year. We appreciate the agency's recognition that EC's practicing in ASCs must be informed of their status well before the start of the performance period. We also urge CMS to permit ECs whose status as an ASC-based EC changes subsequent to the CMS-designated time period to apply for a reweighting to zero of the ACI component. If these ECs are furnishing 75% or more of their services in an ASC, it is unlikely that they will control over the CEHRT and should have their ACI component reweighted to zero.

Exception for MIPS ECs Using Decertified EHR Technology

CMS proposal (82 Fed. Reg. 30078): "We are proposing that a MIPS eligible clinician may demonstrate through an application process that reporting on the measures specified for the advancing care information performance category is not possible because the CEHRT used by the MIPS eligible clinician has been decertified under ONC's Health IT Certification Program. We are proposing that if the MIPS eligible clinician's demonstration is successful and an exception is granted, we would assign a zero percent weighting to the advancing care information performance category in the MIPS final score for the MIPS payment year. We are proposing that a MIPS eligible clinician may qualify for this exception if their CEHRT was decertified either during the performance period for the MIPS payment year or during the calendar year preceding the performance period for the MIPS payment year. We believe that this timeframe is appropriate because the loss of certification may prevent a MIPS eligible clinician from reporting for the advancing care information performance category because it will require that the MIPS eligible clinician switch to an alternate CEHRT, a process that we believe may take up to 2 years."

MGMA comment: As stipulated in the 21st Century Cures Act, ECs are permitted to apply for a hardship exception should their EHR be decertified by ONC. We support CMS' proposal to rely on this statutory provision to assign a zero percent weighting to ACI for ECs who demonstrate that reporting ACI measures is not possible because the CEHRT used was decertified. When a physician practice invests in an EHR that has been subsequently decertified and thus cannot be leveraged for MIPS participation, the process of determining next steps vis-à-vis technology will be long and complicated. Vendors who have been decertified may still attempt to be recertified and most likely will communicate this to their physician practice clients. Typically, practices would much prefer not to have to switch to a new EHR and therefore may lose significant time before initiating the process of selecting a new product. Further, once the practice does decide that it must switch to another software product, that EHR selection process can take considerably longer than the 2 years identified in this proposed rule.

Moving to a new EHR is arduous, expensive, and time consuming. The process often involves the engaging of consultative services, vetting and reviewing numerous product offerings, installation of the new software, moving patient data from the old system to the new one, development of clinical templates and redesign of workflow processes, and the training of clinical and administrative staff. In addition, when practices adopt an EHR, very often they will move to new practice management system software as well (often an integrated product). This, in turn, adds additional cost and time to the overall software transition process. With these issues in mind, we urge the agency to permit an additional hardship year for ECs (for a total of three years, instead of the proposed two years) who have had their EHR decertified and have their ACI performance category reweighted to zero.

ECs facing a significant hardship

CMS proposal (82 Fed. Reg. 30080): “The Quality Payment Program Exception Application will be used to apply for the following exceptions: Insufficient Internet Connectivity; Extreme and Uncontrollable Circumstances; Lack of Control over the Availability of CEHRT and lack of face-to-face patient interaction.”

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

- Concerning the lack of available internet access exception, CMS should publish a definitive explanation for what constitutes “limited access” and provide a list of all counties that have been identified by the Federal Communications Commission, or another agency, as having limited internet access.
- Expand the hardship exception for ECs and group practices who experience unforeseen circumstances that render it impossible to demonstrate the ACI requirements during the reporting period through no fault of their own to a minimum of five years after they begin experiencing these circumstances.
- Add a new hardship exception for ECs and group practices who have switched from one EHR product to another, or experience significant difficulties with their EHR.
- Expand the hardship exception for ECs and group practices practicing for a limited period of time to allow them the additional time to identify, acquire and implement the most appropriate EHR technology. In addition, we recommend the exception be expanded to include those ECs and group practices who have changed specialty taxonomy.
- Grant older ECs eligible for Social Security benefits a hardship exception and have them not be subject to any Medicare payment adjustment. Meeting the ACI requirements requires considerable expenditures of both human and financial capital and it is expected that the return on investment of an EHR installation to support MIPS will require several years of operation.
- Simplify the hardship exception application process by permitting multiple application submission options, including mail, fax and online capabilities. This would allow ECs and group practices additional flexibility for submitting applications.
- Provide email receipt confirmation once a hardship application has been submitted by an EC. This would avoid the situation that some of our members have encountered, where they find out only after the hardship exception deadline has passed that the application was never officially received by CMS.

Issue: Technical Assistance

MGMA comment: We fully support the inclusion of technical assistance to those small and rural providers seeking to participate in the QPP. We urge the agency to work directly with MGMA and

other stakeholders to develop the technical assistance as the specifics of MIPS and APMs are developed to ensure that the appropriate resources are developed and deployed.

It is critical that during the development of the technical assistance, the lessons learned from other programs such as the Regional Extension Centers program are applied. Emphasis should be placed on those providers who have not previously participated in PQRS or the Meaningful Use EHR Incentive Program. It is highly likely these providers will need additional assistance in setting up the basics of participation. Participation in technical assistance should be allowed over a longer time frame as such practices may only truly know what technical assistance they need after initial experiences with participation. Such special consideration should also be given to providers making, or considering, the transition to participation in an APM.

HHS should effectively support rural providers that are (or will be) new to quality measure reporting and/or to small providers who do not have sufficient staff expertise for measurement and improvement activities.

The focus of the majority of technical assistance should be on prevention and wellness, and care coordination services, structured data entry -and the use of claims data, EHR data mining and appropriate coding to ensure rural patients have accurate HCC scores. The technical assistance should be in line with a wide range of IT capabilities, and may be required to include assistance in selecting or upgrading IT components and ensuring providers are using program-compatible browsers and software. Technical assistance may also be useful in disseminating best practices and effectiveness research for practices necessary to success in MIPS or APMs such as care coordination to ensure providers are able to modify their practice to provide services that deliver value to patients without undue cost to the provider and Medicare.

Issue: Continued monitoring of the EHR marketplace

MGMA comment: Section 3007 (a) of the American Recovery and Reinvestment Act states: “The National Coordinator shall support the development and routine updating of qualified EHR technology ...and make available such qualified EHR technology unless the Secretary determines through an assessment that the needs and demands of providers are being substantially and adequately met through the marketplace.” We encourage the close and aggressive monitoring of the EHR marketplace by ONC to ensure that appropriate and cost-efficient products are being offered in a timely manner to physician practices, particularly small practices with limited financial resources. We also encourage early recognition by the ONC of marketplace failures and required subsequent deployment of low-cost alternative software.

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

Issue: Data Blocking Attestation Requirement

In the 2017 final rule, ECs and group practices are required to attest they have cooperated in good faith with surveillance and direct review of their HIT certification by ONC, as authorized by 45 CFR part 170, subpart E. Such cooperation would include responding in a timely manner and in good faith to requests for information (for example, telephone inquiries, written surveys) about the performance of the CEHRT capabilities in use by the provider in the field. In addition, ECs and groups are required to attest to three statements related to health information exchange and the prevention of health information blocking.

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

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

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

MIPS scoring system and aggregate requirements

Duplicative and onerous reporting requirements

CMS proposal (82 Fed. Reg. 30042, 30067): Taking the MIPS proposals in aggregate, group practices and ECs must generally juggle 15 quality improvement metrics to fully participate in MIPS, including six quality measures, four IAs, and five ACI measures.

MGMA comment: With MACRA, Congress set out to streamline and harmonize existing quality reporting programs; we can think of no clearer way to satisfy congressional intent than to award credit across multiple MIPS performance categories for high-impact behavior.

Although there are opportunities to earn bonus points for reporting quality measures or certain IAs using CEHRT, CMS should establish pathways to full MIPS participation using cross-category end-to-end electronic reporting. MGMA offers the following recommendations for recognizing high-

value behavior with cross-category credit:

- ECs and group practices that report quality measures via end-to-end electronic reporting using certified EHRs should not only earn quality performance category points but also automatically earn the base ACI score, amounting to 50% of the ACI performance category.
- ECs and group practices that attest to completing one or more of the IAs requiring CEHRT should not only earn IA credit but also automatically earn the base ACI score, amounting to 50% of the ACI performance category.
- ECs and group practices that attest to completing IAs with a resource use focus should not only earn IA credit but also points toward the cost category.

As implemented, MIPS reflects a continuation of the agency's historically siloed approach to quality reporting, as it consists of four distinct programs under one umbrella. We strongly encourage CMS to restructure MIPS in a manner that permits practices to prioritize effective improvements to patient care, rather than complying with disparate reporting mandates. Whenever possible, CMS should award credit in multiple categories to streamline the program and reduce redundancies.

Performance threshold

CMS proposal (82 Fed. Reg. 30147): CMS proposes to increase the performance threshold from three to 15 points for the 2018 performance period. Scores above 15 points would qualify for a MIPS bonus, while scores below the threshold would receive a penalty. CMS seeks comment about alternative thresholds set at six points or 33 points.

MGMA comment: Of the three proposed performance thresholds, six points is the most reasonable. MIPS is still in its infancy. ECs and group practices will not know how they performed in the first year of MIPS when the final rule is published, nor will they have any feedback about how they can improve on quality and cost measures from CMS. We believe the benefits of maintaining an achievable threshold far outweigh the costs of prematurely increasing the threshold. MGMA strongly urges CMS to gradually increase the performance threshold in 2018 so group practices and physicians may continue to gain experience with the new program criteria and convert feedback to improved performance within the program before being subject to harmful penalties.

Complex patient and small practice bonuses

CMS proposal (82 Fed. Reg. 30135, 30140): CMS proposes to award up to three bonus points to the final MIPS scores of ECs, group practices, virtual groups, and APM Entities that who treat high-risk patients with a goal of protecting access to care for complex patients and avoiding placing MIPS ECs and groups who care for complex patients at a potential disadvantage. Additionally, CMS would add a bonus of five points to the final score of ECs and group practices with 15 or fewer clinicians. Both bonuses would be available only where eligibility criteria are met and the EC or group submits at least one MIPS metric. CMS notes both bonuses are short-term strategies and limits them to the 2018 performance period.

MGMA comment: Although MGMA supports CMS' efforts to level the playing field in MIPS and customize the program for small groups and group practices that treat complex patients, we are worried these fixes are merely band-aids that conceal foundational flaws in the MIPS program and mask an overly complex scoring methodology. Not only are CMS' proposed solutions temporary but they will be finalized, at best, two months before the start of the 2018 performance period. Physician group practices, especially those that treat vulnerable patient populations and those that struggle to find resources to devote to data collection and reporting, need certainty about how the

program will affect their medical group practice. As we have seen in the EHR Meaningful Use Program, last-minute fixes create significant confusion and drain already limited practice resources.

Rather than tweak the program on an annual basis, we strongly encourage the agency to codify these bonuses for at least three years and to enact programmatic reforms to reduce the burdens on group practices. As outlined above, we encourage the agency to reduce the performance period to any 90-day floor, gradually increase the performance threshold, and award cross-category credit for high-impact behavior.

Reporting within one performance category via multiple submission mechanisms

CMS proposal (82 Fed. Reg. 30035, 30110): CMS proposes to allow ECs and groups to submit data on measures and activities via multiple data submission mechanisms, except Web Interface, for a single performance category (specifically, the quality, IA, and ACI performance categories). CMS notes ECs and groups that have fewer than the required number of applicable measures and activities available under one submission mechanism could be required to report data on additional measures and activities via additional mechanisms to receive the maximum number of points in a performance category. CMS would use the highest score if a clinician or group submits the same measures via more than one submission mechanism.

MGMA comment: MGMA supports the increased flexibility that would allow reporting quality measures across multiple data submission mechanisms. We regularly hear from physician group practices that although there are six clinically-applicable quality measures, they are not all available using one submission mechanism. For group practices and ECs that take advantage of this reporting flexibility, we urge CMS to calculate their performance by taking the highest scores for any submitted measures, regardless of how the measure is submitted.

While MGMA supports flexibility for ECs and group practices to report MIPS performance category data via multiple submission mechanisms, we oppose CMS' proposal to hold ECs and groups that report fewer than the required number of applicable metrics responsible for reporting all potential measures via all potential mechanisms. The cost of hiring third-party vendors and the resources required to understand and select clinically-relevant metrics remain significant burdens in this program. In an open-ended question in MGMA's 2017 [Regulatory Burden Survey](#), one respondent commented, "EHR vendors continue to charge additional fees for a 'package' to meet MIPS reporting requirements. It's a gold mine for them."

We are also concerned this policy could drive practices in the direction of reporting for reporting's sake. For instance, if a group practice reports four clinically-applicable quality measures via registry, would the group now be responsible for submitting two additional measures via claims? Given the agency's efforts to reduce administrative burden, it is counterintuitive to drive group practices and physicians to report additional measures simply because more mechanisms are available.

Although we oppose any expansion of the measure validation process as an unwarranted tradeoff for allowing greater flexibility for reporting metrics via multiple submission mechanisms, it is extremely challenging to understand how these two policies would be reconciled because there is very little information available about the MIPS measure validation process. For instance, CMS has stated the new validation process will look similar to the now-defunct Measure Applicability Validation process used in PQRS, but we do not yet know how similar it will be. CMS staff briefed MGMA and the specialty societies about the Eligible Measure Applicability (EMA) determination earlier this year, but many key details – including the clinical clusters – remain unknown. We request clarification about the

MIPS measure validation process and how it would apply in instances in which a group practice or clinician wishes to report measures via multiple submission mechanisms.

Facility-based measurement

CMS proposal (82 Fed. Reg. 30123): CMS proposes a voluntary, facility-based measurement option for clinicians who perform at least 75% of their services in the hospital inpatient or emergency room setting and groups with 75% or more of such clinicians. The agency would calculate the quality and cost scores for interested facility-based clinicians and groups using a hospital's performance in the Medicare Hospital Value-Based Purchasing (VBP) program. CMS proposes to notify facility-based clinicians and groups of their attributed hospital's VBP performance prior to the deadline to elect facility-based measurement.

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

APM scoring standard

CMS proposal (82 Fed. Reg. 30081): Among other things, CMS proposes to add a fourth assessment date to identify participants on the APM Entity's participant list on Dec. 31 in certain circumstances. CMS would also align the scoring methodology of MIPS APMs with ECs and groups in a number of ways, such as measuring quality measure improvement and zeroing out the cost component of the final MIPS score.

MGMA comment: CMS should align MIPS and APMs to encourage physician practices to pursue QP status in eligible APMs by reducing the redundancies for eligible APM participants and removing the regulatory burden of switching from MIPS to APMs. CMS should also harmonize the programs to ensure participants who fall short of QP status would not be at an unfair disadvantage in MIPS. Establishing symmetry between the programs would help group practices prepare for risk-bearing arrangements in APMs, as they would become familiar with the EHR and quality components of these models through MIPS.

While MGMA appreciates CMS' efforts to capture all QPs participating in an APM by adding a Dec. 31 review of the Participant List of certain types of APMs, we continue to urge the agency to notify APM Entities that they are exempt from MIPS as early as possible. As implemented, clinicians participating in APMs must prepare to participate in and begin collecting MIPS data prior to knowing if they would meet thresholds to be considered partial QPs or QPs.

To avoid confusion on what information would be needed for MIPS and the APM model, CMS should structure the APM Scoring Standard so there would be no additional reporting burden on ECs and groups in APMs. We agree with CMS that cost should not be assessed because resource use reduction is an underlying goal of all APMs. As discussed in our comments on the IA category, ECs and groups participating in APMs should automatically receive the total points possible for IA. To achieve the

savings that would be required in APM models, APM Entities would need to engage in multiple types of IAs, including activities focused on coordination across the care continuum and beneficiary engagement. In recognition of the current level of effort APMs devote to performance, practice improvement and CMS' overall intent to drive payment into APMs, APM participation should be automatically awarded full IA points. At a minimum, CMS should allow reporting of IAs to occur at the APM Entity level, rather than the aggregate of TINs or individual ECs, to reduce reporting burden.

Finally, MGMA reiterates its position that ACI should not be scored as part of the APM Scoring Standard but rather use of CEHRT should be incorporated into the APM models. At a minimum, CMS should assess ACI at an APM Entity level. For example, an APM Entity could meet ACI if they attest to using data produced from CEHRT for population health or information exchange, such as health risk assessment, forecasting, other analytic modeling, feeding registries and exchange with participant network through an HIE or other mechanism.

Advanced Alternative Payment Models (APMs)

MGMA urges CMS to prioritize expansion of the Advanced APM pathway in 2018 and welcomes the opportunity to work with the agency toward this common goal. While it is true that the number of qualified participants (QPs) in Advanced APMs are likely to increase from 2017, this is based on increased participation in models that were previously finalized. CMS does not propose to add a single APM to the list of Advanced APMs for the 2018 performance year. Moreover, after the recent proposal to cancel implementation of the mandatory Episode Payment Models and the Cardiac Rehabilitation Incentive payment model and scaling back mandatory participation in the Comprehensive Care for Joint Replacement Model, this figure is likely to decrease. Given the cancellation and scaling back of these mandatory models, coupled with the fact that the Comprehensive End-Stage Renal Disease Care and Oncology Care Models are not currently accepting new applicants, there are fewer Advanced APMs opportunities for applicants next year than there were in 2017. While MGMA agrees with CMS that mandatory, government-created models create undue burden on medical group practices and hospitals and stifle physician-led innovation, we believe there are a few immediate steps the agency should take to expand the Advanced APM pathway. For instance, CMS should consider Medicare Advantage APMs as Advanced APMs, set a more appropriate revenue-based nominal amount standard and formalize a process and timeline by which HHS would test and approve new Physician-Focused Payment Models. We look forward to continuing to work with the agency to achieve our shared goal of supporting physician group practices as they transform their care delivery from volume-based to value-based.

Medical Home Model EC limit

CMS proposal (82 Fed. Reg. 30172): Participants in Round 1 of CPC+ would be exempted from the 50-clinician limit for the Medical Home Model (MHM) financial risk standard because this requirement was finalized after practices had already signed agreements with CMS to participate in CPC+ Round 1. Future CPC+ participants would not be exempt. It would continue to be required that MHMs have a primary care focus.

MGMA comment: While MGMA supports this exception for Round 1 CPC+ participants, we maintain our strong opposition to the 50-clinician limit for the MHM financial risk standard. In MACRA, Congress supported the expansion of medical homes as a cornerstone of value-based payment reform and to date CMS has not created any medical home alternatives outside of MHMs that would qualify as Advanced APMs. Thus, by excluding larger organizations from qualifying as MHMs, CMS is essentially forcing them into MIPS and undercutting its own goal of driving widespread

participation in innovative value-based payment models. There is also no reason to restrict Advanced APM MHMs to solely primary care clinicians and services. These models are comparable in design and share the same goal as primary care-based MHMs. MACRA does not prohibit specialty models from qualifying as MHMs and many specialty models fulfill the vast majority of characteristics of a MHM outlined in §414.1305. Further, specialty models already qualify as MHMs for purposes of MIPS. It is inconsistent to recognize these MHM models in one pathway of the QPP, but not the other.

Extending the current revenue-based nominal amount standard

CMS proposal (82 Fed. Reg. 30173): The revenue-based nominal amount standard for non-MHM Advanced APMs would be maintained at the current level of 8% of average estimated total Medicare Parts A and B revenue for the 2019 and 2020 qualified participant (QP) performance periods. The standard for future performance periods would be addressed in future rulemaking.

MGMA comment: CMS has never provided its methodologies for arriving at this 8% figure for the nominal amount standard, and MGMA, along with various other industry stakeholders, have repeatedly asserted that 8% in fact represents levels of risk substantially beyond “more than nominal.” Accordingly, we implore CMS not to increase this standard in future years any amount beyond 8% for this reason and to ensure stability and predictability for ECs. Both other nominal financial risk standards are open ended and we see no reason why the revenue-based standard should be any different.

Additionally, we strongly support CMS’ logic behind implementing a more gradual increase in the MHM risk standard and encourage the agency to apply this same logic to the general nominal amount standard, as doing so would provide a much more effective onramp to widespread Advanced APM participation, particularly in these first critical years. Specifically, we recommend CMS set the nominal amount standard at 4% in 2018, 6% in 2019-2020 and 8% and 2021 and beyond. We remind CMS that Advanced APM Entities will already be facing increasing risk levels due to the statutory Advanced APM participation threshold, which will triple over the course of just a few years. This already represents a substantial increase in risk levels and increasing the nominal amount standard at the same time would likely become too high a barrier for many Advanced APM Entities to overcome and could lead to drastic cuts in participation in value-based payment models.

Clarifying the nominal amount standard as a percentage of total APM revenues

CMS proposal (82 Fed. Reg. 30173): When total risk is not expressly defined in terms of revenue for a model, CMS would calculate an average of the estimated total Medicare Parts A and B revenue at risk for all APM Entities within the APM, and if that average revenue at risk was equal to or greater than 8%, the APM would satisfy the generally applicable revenue-based nominal amount standard.

MGMA comment: MGMA urges CMS not to finalize these revenue calculations as proposed, as doing so could disadvantage smaller APM Entities aiming to achieve QP status. Setting a universal standard based on the average of collective revenues would be much higher for smaller APM Entities proportionate to their revenue stream and in most cases, would be financially untenable, resulting in an almost universal barrier to Advanced APM participation for smaller APM Entities. Further, this adverse selection would cause the average to grow even higher, leading to a new type of death spiral that would drive larger and larger APM Entities from being able to participate until it potentially devastates the future Advanced APM market. From a logistical standpoint, adopting this approach would also delay all such QP determinations until the end of the year when all revenue data could be collected and an average calculated.

Calculating the generally applicable nominal amount standard

CMS proposal (82 Fed. Reg. 30173) The nominal amount standard would be set at 8% of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

MGMA comment: Part B drug costs should be excluded from these calculations. The price paid to practices for Part B drugs essentially covers the wholesale cost of the drug itself with very little to no margin to the practice, so to count this towards revenue is misleading and could potentially be devastating to practices, particularly those specialties where drugs incorporate a sizable portion of their products and services, such as oncology and rheumatology.

Revenue-based nominal amount standard for small and rural practices

CMS proposal (82 Fed. Reg. 30173): CMS seeks comment on whether it should establish a separate, potentially lower standard for small practices and those in rural areas.

MGMA comment: The creation of a more appropriate, lower risk standard specifically for small and rural practices would encourage and enable more of these practices to successfully participate in risk-bearing models. Numerous studies have demonstrated a large chasm in Advanced APM participation between smaller and larger practices. There are multiple reasons for this: they face unique logistical and demographic challenges, do not have the same resources, and do not possess the same financial margins to weather taking on larger amounts of risk. Establishing a separate, lower standard for these types of practices would give CMS the opportunity to capture an entire population of new practices that would have otherwise never found it feasible to participate in higher risk models, or those that tried the existing higher risk models, found the risk levels unworkable, and would no longer be participating anyway.

We disagree with CMS' concern that creating a lower standard may reduce the effectiveness of Advanced APMs in lowering Medicare expenditures. As Advanced APMs are generally voluntary, we contend that the focus for increasing Advanced APMs' effectiveness in reducing Medicare expenditures should be expediting widespread industry buy-in and participation in Advanced APMs – a goal the Administration has repeatedly emphasized. Small and rural practices would still have the option to participate in models that feature higher levels of risk and reward. In fact, it would be unlikely for a practice that was performing well in an Advanced APM with higher levels of risk and reward to retreat to a lower level. Establishing a lower threshold for small and rural practices is therefore unlikely to reduce existing participation in higher risk models and would be no less effective in reducing expenditures than the current single standard. It would, however, provide CMS with more latitude to design models that would otherwise fail to meet the Advanced APM criteria and specifically target small and rural practices that likely otherwise would have never considered it viable to participate in an Advanced APM.

We would like to emphasize CMS' own point that this risk standard would be a minimum. Creating a lower standard would in no way commit the agency to exclusively designing models that meet this minimum standard, it would simply allow the agency the ability, if it should desire at a future point, to create models with structural and risk elements that are more appropriate for small and rural practices. Considering these types of practices serve some of the most vulnerable patient populations and often have less sophisticated support infrastructures and resources, implementing value-based strategies has the potential to produce even wider margins of returns in these practices than their larger and more urban counterparts. By establishing a separate standard for small and rural practices, CMS would tap

into a largely uncharted market that has even greater potential for improvement and savings without undercutting its current Advanced APM successes.

MGMA urges CMS not to impose unnecessary restrictions on this standard such as not applying it to small or rural practices who join with larger APM Entities particularly in these introductory years, as doing so would only handicap its purported goal of encouraging Advanced APM participation by these types of practices. In the interest of consistency and reducing further complexity in the QPP, we recommend CMS use the same definitions for small and rural practices currently used for MIPS scoring and base this lower standard on the proposed MHM nominal amount standard.

MHM and Medicaid MHM nominal amount standard

CMS proposal (82 Fed. Reg. 30174): The nominal amount standard for Medicare MHMs would increase more gradually, starting at 2% in the 2018 performance year (as opposed to 2.5%) and increase by 1% thereafter until 2021, at which point it would remain at 5%. The Other Payer Medicaid MHM nominal amount standard would similarly start at 3% in the 2019 performance year and increase by 1% each year until capping at 5% in 2021.

MGMA comment: MGMA supports a more gradual progression toward the 5% nominal amount standard for MHMs to enable greater flexibility in setting financial risk thresholds, encourage more participation in MHMs, and allow for more success in achieving Advanced APM Entity status and therefore reinforce the overall sustainability of MHMs. We also strongly support the proposal to cap this amount at 5%, as we agree with the agency that MHMs typically have more limited experience with and ability to take on risk.

QP and Partial QP determinations for Advanced APMs starting or ending during a Medicare QP performance period

CMS proposal (82 Fed. Reg. 30175): Advanced APMs that start or end during a given QP performance period would have their QP threshold scores calculated using only the dates in which APM Entities participated in active testing, provided it was for a minimum of 60 or more continuous days. This policy would not affect QP determinations for clinicians participating in multiple Advanced APMs or Other-Payer APMs.

MGMA comment: Basing QP determinations only on dates in which APM Entities participated in active testing would prevent affected APM Entities from being unfairly disadvantaged in their QP calculations. We further contend this policy should be applied to all QP determinations, including Other-Payer APM Entities and eligible clinicians who participate in multiple Advanced APMs based on this same logic. CMS' logic that "eligible clinicians have more control over the start and end dates of payment arrangements with other payers" is naive. Individual clinicians and practices often have very little control over when Other Payer APMs in which they participate get off the ground.

Other Payer MHMs

CMS proposal (82 Fed. Reg. 30180): Similar to MHMs, Other Payer MHMs would be required to have a primary care focus. CMS seeks comment on whether it would be appropriate to establish a separate, lower risk standard for Other Payer MHMs that would mirror the Medicaid MHM risk standards, as well as any special considerations for Other Payer MHM criteria.

MGMA comment: MGMA supports a separate, lower risk standard for Other Payer MHMs for the same reasons expressed by CMS, namely that these types of models often have less exposure to risk and would accordingly be less inclined to participate in Advanced APMs if subject to the standard Other Payer risk standards. This standard should mirror that for Medicare and Medicaid MHMs given there is no reason Other Payer MHMs should be disadvantaged in any way, particularly as they are more widespread and developed than government models at this point. Furthermore, CPC+ is a multipayer model, so establishing a consistent standard would further support the growth and development of CPC+ and reduce overall complexity in the QPP. Based on MGMA's consistent principle of not arbitrarily restricting participation in Advanced APMs, we do not support the 50-clinician cap nor imposing any specialty restrictions for Other Payer MHMs. We reiterate our earlier points that MACRA does not restrict specialty models from qualifying as MHMs and many specialty models fulfill the vast majority of characteristics of a MHM outlined in §414.1305. It is inconsistent to recognize these models as MHMs in MIPS, but not APMs.

Other Payer Advanced APM nominal amount standard

CMS proposal (82 Fed. Reg. 30181): The nominal amount standard for Other Payer Advanced APMs would entail three separate measures of risk (marginal risk, minimum loss rate, and total risk), whereas Advanced APMs are only evaluated on total risk. A second Other Payer Advanced APM nominal amount standard based on revenue would be added in addition to one based on expected expenditures, i.e., the benchmark. This would match the revenue-based nominal amount standard for Advanced APMs at 8% of revenues for the 2019 and 2020 performance periods. CMS solicits comments on whether this standard is appropriate and whether it should establish a separate, potentially lower standard specifically for small and rural practices.

MGMA comment: If an Other Payer Advanced APM Entity is willing to accept substantive levels of total risk, this should be considered a sufficient minimum standard for bearing nominal risk, as is the case for Advanced APMs. Adding additional, unnecessary stipulations to becoming an Advanced APM would only discourage development of and participation in new Other Payer APMs, particularly at the outset. As CMS points out elsewhere in the proposed rule, this standard is only a minimum. Individual models could always require higher levels of risk and this level could be theoretically increased over time as practices gain more experience with Other Payer APMs. In the interim, the baseline should be kept as minimally burdensome as possible to achieve the joint industry and CMS goal of widespread participation in Advanced APMs.

As noted in our comments pertaining to the nominal amount standard, we feel that 8% constitutes levels of risk substantially beyond "nominal." Accordingly, we implore CMS not to increase this standard beyond this level for this reason and to ensure stability and predictability for ECs. The revenue-based standard should also be kept open-ended to align with both other nominal financial risk standards. MGMA supports CMS' logic behind implementing a more gradual increase in the MHM risk standard and encourage the agency to apply this same logic to the general nominal amount standard, as doing so would provide a much more effective onramp to widespread Advanced APM participation, particularly in these first critical years. Specifically, we recommend CMS set the nominal amount standard at 4% in 2018, 6% in 2019-2020 and 8% and 2021 and beyond. We remind CMS that Advanced APM Entities will already be facing increasing risk levels due to the statutory Advanced APM participation threshold increases that are up to triple current levels over the course of just a few years. This already represents a substantial increase in risk levels and increasing the nominal amount standard at the same time would likely become too high a barrier for many Advanced APM Entities to overcome and could lead to drastic cuts in participation in value-based payment models.

We agree with the agency that smaller and rural practices have less resources and struggle to meet the same risk standards of larger practices and support a more appropriate, lower risk standard specifically for small and rural practices. We believe it would encourage and enable more of these practices to successfully participate in risk-bearing models. Establishing a separate, lower standard for these types of practices would also give CMS the opportunity to engage an new practices that would not otherwise participate in higher risk models, or those that tried the existing higher risk models, found the risk levels unworkable and would no longer participate anyway. Considering these types of practices often serve some of the most vulnerable patient populations and have less sophisticated infrastructures, they stand to see even higher returns in terms of reduced expenditures by implementing simple value-based strategies such as enhanced care coordination efforts. CMS should seek every opportunity to tap into this market that has the potential to yield substantial reductions in healthcare spending, including establishing more appropriate risk expectations.

MGMA urges CMS not to impose unnecessary restrictions on this standard, as doing so would only handicap its purported goal of encouraging Advanced APM participation by these types of practices. In the interest of consistency, we also implore CMS to apply the same definition of a rural and practice used for MIPS scoring to evaluate whether a practice would qualify as rural for purposes of the revenue-based nominal amount standard for both Advanced APMs and Other Payer Advanced APMs. For the sake of reducing further complexity in the QPP, we suggest the agency use the same definitions for small and rural practices currently used for MIPS scoring and align this standard for small and rural practices with the proposed MHM nominal amount standard.

Other Payer Advanced APM determination process

CMS proposal (82 Fed. Reg. 30183): Payers, states and territories (in the case of Medicaid models) would be able to request determinations prior to each performance year, starting with the 2019 performance year for certain payment arrangements including Medicare Health Plans, CMS Multi-Payer Models and those authorized under Title XIX, and in the 2020 performance year for others. The submission period would occur in the year prior to the relevant performance year, though the exact timeframe would vary by payer to align with existing CMS processes and other relevant deadlines to the extent possible. Following the payer-initiated demonstration process, APM Entities and ECs would have their own opportunity to submit payment arrangements not already nominated.

MGMA comment: MGMA has substantial concerns about the complexity of the proposed Other Payer Advanced APM determination process, including the feasibility of an annual application process. While we understand CMS' intent to maintain up-to-date information given potential changes from year to year, CMS could still maintain accurate records while greatly minimizing burden on all parties involved, including their own staff, by not requiring applications be resubmitted each year when there are no changes. We urge CMS to leave determinations open ended and allow payers, APM Entities and ECs to make any changes as necessary during an annual open application period. If CMS does set expiration dates for Other Payer Advanced APM determinations, determinations should be valid for a minimum of five years to minimize the administrative burden and provide certainty to physician group practices devoting significant resources to success in Advanced APMs.

In many ways, the private payer market is outpacing public payers when it comes to the development and sophistication of APMs, and many MGMA member practices are already engaging in innovative payment models with commercial payers. We see no reason why CMS should delay recognizing these physician group practices who have supported and invested in CMS' vision by partaking in innovative care models. By proposing to allow determinations for Medicaid, CMS multi-payer models and Medicare Advantage (MA) plans to begin in 2019, CMS demonstrates that it has the capability to begin

evaluating Other Payer determinations in 2019, so we see no reason why CMS would arbitrarily delay those determinations if private payers are willing and able to supply the necessary data. Accordingly, we urge CMS to begin all Other Payer determinations in 2019.

Guidance and submission form

CMS proposal (82 Fed. Reg. 30183): CMS intends to release additional information regarding the process and forms for the Other Payer determination process at a future date prior to the first submission period.

MGMA comment: MGMA would like to emphasize the importance of making vital details about the forms and submission process as soon as possible. The QPP has been hindered by the absence of vital information regarding participation eligibility in MIPS and APMs up to halfway through the performance year. This hinders practices' ability to succeed in MIPS by cutting short their window to plan and prepare. A similar rollout could be equally as damaging to the success of Other Payer Advanced APMs. We appreciate the Administration's expressed interest in stakeholder feedback and will intend to submit more precise comments regarding the Other Payer Advanced APM determination process as more information is made available and look forward to working with the Administration to ensure a smooth rollout.

Incomplete information

CMS proposal (82 Fed. Reg. 30184): Should the information submitted be inadequate or incomplete, CMS would notify the submitter and allow 10 business days to submit the required information.

MGMA comment: We appreciate CMS's recognition that there will likely be a learning curve in the first few years of this voluntary Advanced APM determination request process by providing a second opportunity for submitters to provide missing documentation. However, given the complexity of requirements and magnitude of supporting documentation, MGMA believes 10 business days is an insufficient timeframe for a submitter to internally communicate with the appropriate parties, resolve any issues and collect and resubmit the appropriate information to CMS. While we understand the importance of keeping the determination process on track, we believe extending the resubmission window will have exponential returns in terms of APM Entities' ability to comply with documentation requirements and will therefore lead to increased participation in Advanced APMs. CMS should avoid restricting the pathway to Advanced APM participation due simply to an arbitrarily short turn-around for paperwork that would potentially force applicants to wait an entire additional calendar year to resubmit, particularly given the limited timeframe to earn the 5% bonus.

Final determinations

CMS proposal (82 Fed. Reg. 30184): All Other Payer Advanced APM determinations would be considered final and not subject to reconsideration.

MGMA comment: MGMA takes issue with the fact that there would be no opportunity to appeal a determination. Payers, clinicians and APM Entities would have invested a significant amount of time, energy and resources to build an APM from the ground up, supporting the Administration in its drive to value-based reimbursement. It would be short-sighted and counter to the agency's goals to reject qualifying entities with no recourse, potentially for a trivial reason, and not allow them another opportunity to resubmit for an entire year. These first few years are particularly critical, given the inevitable learning curve and limited window to earn the 5% lump sum incentive payments. By

instituting a sink-or-swim approach, the agency could impede its goal of moving the healthcare industry toward value-based reimbursement. Not only would rejected APMs reevaluate continuing to invest extensive resources participating in an APM, a wave of rejections would likely dissuade the future development of new APMs. Therefore, we urge CMS to work with Other Payer Advanced APM applicants and provide feedback explaining why an initial determination application was not approved and to allow submitters at least one additional opportunity to appeal a rejected determination, address any areas of concern and resubmit for consideration. In the interest of lending legitimacy to the process, we recommend this second determination be administered by a separate department within the agency. We urge the agency to install a formal appeals and secondary determination process, as it would have very little to no downside cost for the agency but would yield exponential returns in terms of private sector support of APMs.

CMS notification and posting of Other Payer Advanced APMs

CMS proposal (82 Fed. Reg. 30184): For both the payer-initiated and clinician-initiated processes, CMS would notify submitters of determinations “as soon as practicable” and post a list of approved Other Payer Advanced APMs prior to the start of the relevant performance period.

MGMA comment: MGMA urges the agency to formalize a mandatory turnaround for Other Payer Advanced APM determination requests. A transparent and predictable process for approval as an Advanced APM is vital to ensuring continued private sector development of APMs. CMS noted in the QPP Year 1 final rule that applications submitted by Sept. 1 would receive a determination prior to Dec. 1, so it appears a 60-day turnaround is considered reasonable by the agency. We ask CMS to formalize through rulemaking this timeline for returning final determination requests so that private sector APM developers and participants can appropriately plan.

Medicare Advantage (MA) Advanced APMs

CMS proposal (82 Fed. Reg. 30190): CMS seeks comment on ways to award credit toward the Medicare Option for participating in MA Advanced APMs.

MGMA comment: MGMA supports counting MA plans toward the Medicare QP threshold. According to a June 2017 [brief](#) by The Henry J. Kaiser Family Foundation, one out of every three Medicare beneficiaries is now enrolled in a MA plan. As MGMA and other stakeholders have [expressed](#) in past comment letters, MA plans can and should be counted toward the Medicare QP threshold under the beneficiary count alternative. MACRA does not limit the beneficiary count standard to Medicare fee for service (FFS) patients. CMS can and should include MA enrollees in the patient count methodology beginning with the 2019 performance period. To avert unintended consequences of diluting the denominator for existing Medicare QP calculations, we recommend CMS build on its current multi-step approach in which traditional Medicare FFS payment and patient thresholds would be calculated first, after which Advanced APM Entities that do not meet either threshold would have a second Medicare patient count threshold calculated using combined Medicare FFS and MA patients. If an Advanced APM Entity is not captured in either of these steps under the Medicare threshold, it would then proceed to the All-Payer QP threshold calculations.

Use of CEHRT

CMS proposal (82 Fed. Reg. 30194): For the payer-initiated process, CMS would a payer provide evidence that the CEHRT criterion is satisfied. For the EC-initiated process, CMS would presume an

Other Payer Advanced APM satisfies the 50% CEHRT use criterion given the agency receives documentation demonstrating that the APM requires ECs to use CEHRT.

MGMA comment: MGMA generally supports this proposal, given that it appropriately recognizes use of CEHRT while minimizing burdensome documentation or attestation requirements, particularly at the individual clinician level. However, because contracts between payers and APMs may not use precise language identifying the use of CEHRT and clinicians have little control over the exact language used in these contracts, we urge CMS to give deference to common synonyms, such as EHR and EMR.

Calculation of threshold scores and QP determinations under the All-Payer Combination Option

CMS proposal (82 Fed. Reg. 30198): CMS would make two separate All-Payer QP determinations during the performance period: one based on data from Jan. 1 through March 31 and another overlapping determination based on data from Jan. 1 through June 30. Alternatively, CMS would use only the first period. The same time periods would be used for Medicare data and that of other payers. The agency proposes this shortened timeline in the interest of providing ECs with sufficient time to make their own decision regarding MIPS participation and possibly submit required information by the deadline. CMS would allow the same 90-day claims run out period for other payers as it would for MA APMs but solicits comments on whether a shorter timeframe would be more appropriate.

MGMA comment: MGMA is disappointed the agency would further silo the QPP by proposing a separate All-Payer Combination Option QP determination timeline that differs in both length and format from the Medicare Option, rather than taking this opportunity to reduce complexity in the program by syncing the All-Payer Combination Option determination timeline with the existing Medicare Option timeline. In addition, APMs hoping to qualify under the All-Payer Combination Option would be significantly handicapped by this proposed timeline. APMs qualifying under the Medicare Option are provided with three sequential timeframes in which to meet patient or payment thresholds. However, those hoping to qualify under the All-Payer Combination Option would be tied to their data from January through March, regardless of whether their data from April through June ended up being counted or not—a major disadvantage compared to their counterparts evaluated under the Medicare Option who have three distinct opportunities to qualify.

In proposing a different timeframe to make All-Payer Combination Option QP determinations, the agency violates its own principle expressly stated in this proposed rule that “QP determinations should be based on an eligible clinician’s performance over a single period of time” and “lack of alignment compiling participation information from multiple time periods for the purposes of making QP determinations would not appropriately reflect the structure of QP assessment...” (82 Fed. Reg. 30200) To maintain consistency to ensure QP determinations are both accurate and statistically comparable, the agency should use the same timeframe standards to calculate QP determinations for both the All-Payer Option and Medicare Options. Otherwise, the Medicare component under the All-Payer Option would be completely different than under the Medicare Option because they are based on two different windows of time, despite being based the same exact performance data. This could result in some APMs achieving QP status as Advanced APMs and others falling short based on the Medicare component, all due to mathematical manipulations of the same data because one was calculated under the Medicare Option and another was calculated under the All-Payer Option.

Furthermore, the primary justification CMS gives for expediting the timeline for All-Payer Combination Option QP determinations is that it would provide clinicians with advance notice to make appropriate MIPS participation decisions for the given performance period. This logic is flawed on two

levels. First, if the timeline for All-Payer QP determinations was in fact aligned with the current Medicare QP timeline, practices and clinicians qualifying in either of the first two periods (January-March and April-June) would receive QP determinations at the same time as compared to the proposed policy, so they would not be benefitted by this proposed policy. In fact, this proposed policy would make them worse off by preventing clinicians who would have otherwise qualified in the third window (July-August) from qualifying.

Second, MGMA is concerned the agency is perpetuating the same misguided notion of the previous Administration that participating in MIPS is something that can occur at the end of the participation year with the flip of a switch. On the contrary, before a practice or clinician can capture any MIPS data, a number of important logistical decisions need to be made and processes put in place. Clinicians and groups must determine, for instance, which clinicians are eligible to participate, then based on that information evaluate which reporting mechanism or mechanisms would be most appropriate for their needs, select appropriate measures and activities to focus on and capture data for, train staff on reporting protocols, and so on. The vast majority of these reporting mechanisms are not free, and most do not come cheap. Participating in even one Advanced APM is already a major effort and expense of finite practice resources, particularly for small and rural practices. To expect practices to purchase a qualified registry or other reporting mechanism and spend all that time training staff and collecting that data on top of this purely as a backup is unrealistic and financially infeasible for many practices. This is precisely the reason MACRA exempted practices participating in Advanced APMs from MIPS in the first place. While we couldn't agree more with the agency on the importance of providing practices and clinicians "sufficient notice" of their QP determinations so that they can participate and report for MIPS in the same performance year, to be truly "sufficient" this notice would have to occur prior to the performance year, particularly if CMS moves forward with requiring full-year reporting of quality data.

MGMA has repeatedly emphasized the numerous advantages to reducing the performance period for MIPS in previous comment letters and in this letter, including the notable advantage that reducing the performance period for MIPS would allow CMS to move the performance period closer to the actual payment year. This would in turn allow CMS to make Advanced APM QP determinations that are both closer to the payment year, and well in advance of the corresponding MIPS performance period. MGMA appreciates this would require a larger overhaul of the current QPP timeline, and we would like to again express our desire to work with the Administration toward this in the future, but for the more immediate purpose of commenting on the timeline for All-Payer QP determinations proposed in this rule, we would like to emphasize that receiving a QP determination in September or October verses December of the performance period makes little difference to a clinician or practice's ability to successfully participate in MIPS. It could, however, do a great deal of damage in terms of clinicians' ability to qualify as QPs under the All-Payer Option. Therefore, we urge the agency not to finalize this policy as proposed, and to instead finalize an All-Payer QP determination timeline that mirrors the existing timeline for the Medicare Option.

In the interest of keeping the timeline for QP determinations as consistent as possible and given the afore-mentioned points that moving up the timing for QP determinations by a matter of months would yield little benefit in terms of MIPS participation, MGMA urges CMS to retain the same 90-day claims run out window for QP determinations made under the All-Payer Option as is currently used under the Medicare Option.

QP determinations at the EC level

CMS proposal (82 Fed. Reg. 30200): All-Payer QP determinations would be made at the individual EC level only. CMS cites significant logistical challenges with collecting enough other payer data to effectively make QP determinations at the APM Entity group level.

MGMA comment: MGMA has a number of concerns with CMS' proposal to make QP determinations under the All-Payer Combination Option solely at the individual EC level. This proposed approach runs counter to CMS' own philosophy of holding APM Entities collectively accountable for performance and risk. CMS itself states that "it is generally preferable to make QP determinations at the APM Entity level" for this reason and only recommends making these determinations at the clinician level due to anticipated logistical challenges in obtaining the necessary information, including participation lists and payment and patient data (82 Fed. Reg. 30200). MGMA disagrees with this reasoning. In many cases, private payer APMs collect very sophisticated data that in many ways mirror and in some cases even exceed the sophistication of data CMS collects for its own models. CMS provides insufficient rationale for its assumption that private payer models could not supply the same information Medicare models are required to provide, especially if these standards are expressly laid out in advance. CMS could institute formatting requirements that would ensure consistency of private payer data and make it easier to analyze and compare. Alternatively, CMS could have the payers themselves make the necessary numerator and denominator calculations and send only this data to CMS but reserve the right to audit payers for patient and payment records and methodologies. This would drastically reduce the work on CMS' end, streamline data into a more consistent format and provide the agency with all of the necessary data to make All-Payer QP determinations.

One of the biggest advantages to the APM structure is that it allows for more flexibility and variation in design so that a wider range of practice types can succeed in value-based reimbursement models. It is problematic for CMS to undercut this very principle when it comes to making its own QP determinations. CMS should not seek to inhibit itself with unnecessary restrictions. Rather, it should give itself as much discretion as possible so that it can consider the unique design elements of each model to make QP determinations at the most appropriate level. Certainly, there will be some cases like the one CMS describes in the proposed rule in which it makes the most sense to make QP determinations at an individual clinician level. However, there will be just as many, if not more scenarios where participation decisions are required at the TIN-level, just as CMS requires participation at the TIN-level for certain Medicare APMs. To arbitrarily require QP determinations for these types of models be meticulously calculated for every individual clinician would be nonsensical and waste CMS' time and money. CMS has already set a precedent in valuing flexibility by conducting MIPS scoring at varying levels, at the individual clinician, TIN or APM Entity levels. MGMA urges the agency to mirror this existing policy and have APM Entities or participants elect to be evaluated at the clinician, practice or APM Entity level and have this determination status applied to all participating clinicians. Doing so would still allow CMS to make calculations at the clinician level if that is what is most appropriate, but would not force the agency to do so in every case when it would make no logical sense. Particularly with the initial rounds of All-Payer QP determinations, it is important CMS start with a more flexible approach and learn through experience which changes or additional restrictions may prove effective and address this as necessary through future rulemaking.

Physician-Focused Payment Models (PFPs)

CMS proposal (82 Fed. Reg. 30207): Under previously finalized rules, PFPs must include Medicare as a payer. CMS seeks comment in this proposed rule on whether to broaden this definition to include

payment arrangements with Medicaid or the Children's Health Insurance Program (CHIP). MA plans would still not qualify.

MGMA comment: MGMA strongly supports expanding the definition of a PFPM to include models with these payers, as it would allow greater opportunities for practices to participate in Advanced APMs and become QPs, particularly for clinicians and practices in certain specialties that treat patients outside of the traditional Medicare population. We urge the agency to expand this definition further to include MA plans. MA plans are becoming increasingly popular among Medicare beneficiaries. CMS has acknowledged this growth by seeking comment about including MA patients and payments in the Medicare Option QP threshold. It would be consistent to also include MA plan models as PFPMs.

PFPM Technical Advisory Committee (PTAC) Review Process of PFPM Proposals

CMS proposal (82 Fed. Reg. 30209): CMS reiterates it would give serious consideration to PFPM recommendations from PTAC, though it is not required to test these proposals.

MGMA comment: While MGMA appreciates the agency's support in this process, we urge CMS to formalize through rulemaking a process and timeline for responding to PTAC recommendations. The PFPM process is a promising way to achieve the Administration's goal of approving more physician-led and developed Advanced APMs and widening the pathway to participation in Advanced APMs. However, without a codified process that ensures these recommendations will ever be acted on by HHS, the PTAC process has little credibility. Doing the background research to design a new model from the ground up that can withstand the scrutiny of both PTAC and CMS requires a significant investment in time and resources and after a certain point of inaction on these recommendations, physician groups will grow weary and have little incentive to put the work into developing new models. Eventually, PTAC and the PFPM development process would cease to serve any practical purpose. To date, two of three proposals were recommended to the Secretary for limited-scale testing and we have yet to see a response from HHS more than 60 days later. To ensure the future viability of this promising APM pipeline, we urge the agency to formalize a process and timeline by which CMS or the Secretary will respond to PTAC recommendations. Specifically, MGMA believes 60 or 90 days would be an appropriate timeframe.

MGMA also urges CMS to work with PTAC and PFPM developers to provide them with any necessary data and technical assistance they need to be successful to the fullest extent possible. These developers are investing countless hours and resources into building these models all to support CMS' goal of developing new innovative payment models that could serve as future Advanced APMs. CMS in many cases retains the unique ability to collect clinical and payment data across payers and should be doing everything it can to support these developers with the logistical support and data they need to be successful. A little bit of effort in this regard can go a long way towards helping these models being successfully tested and implemented, which would advance CMS' goal to widen the pathway to participation in Advanced APMs.

Conclusion

We appreciate the opportunity to share our comments regarding the framework for MIPS and APMs and to offer our recommendations to improve and simplify these programs to support groups practices as they transform their organizations. Should you have any questions, please contact me at agilberg@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs