



September 13, 2021

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

Re: File Code CMS–1751–P. Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements.

Dear Administrator Brooks-LaSure:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the calendar year (CY) 2022 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule, published in the Federal Register on July 23, 2021 (86 Fed. Reg. 39104).

MGMA is the premier association for professionals who lead medical practices. With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups in which more than 350,000 physicians practice. These groups range from small private practices in rural areas to large regional and national health systems and cover the full spectrum of physician specialties and organizational forms.

Key Recommendations

MGMA appreciates the Centers for Medicare & Medicaid Services' (CMS') leadership in improving Medicare and respectfully offers the following comments in response to the CY 2022 Physician Fee Schedule (PFS) proposed rule. In summary, we encourage the agency to:

- **Urge Congress to provide a positive update to the Medicare conversion factor in CY 2022 and all future years.** MGMA is deeply concerned with the estimated reduction to the CY 2022 conversion factor and its potential impact on medical group practices. The cuts stemming from the 3.75% decrease in the CY 2022 conversion factor paired with the potential effects of Statutory Pay-As-You Go (PAYGO) and the conclusion of the 2% Medicare sequester moratorium is simply unsustainable.
- **Expand its proposal to cover not only audio-only mental health services, but additional codes as well, such as evaluation and management (E/M) services.** Audio-only services

are a lifeline to patients who are unable to attend in-person visits or do not have access to the tools necessary to conduct face-to-face telehealth visits. MGMA believes that CMS should cover and pay for audio-only E/M services beyond the conclusion of the COVID-19 public health emergency (PHE).

- **Finalize the proposal to delay the payment penalty phase of the Appropriate Use Criteria (AUC) program until Jan. 1, 2023, or the Jan. 1 following the end of the PHE and use its authority to reduce burdens associated with the program.** Due in part to a lack of education and outreach on the part of CMS, many group practices are not able to comply with the AUC program starting Jan. 1, 2022. MGMA supports the proposal to delay the payment penalty phase of the program, which is set to begin Jan. 1, 2022, but encourages CMS to use its authority to reduce administrative burden and work with Congress to find potential legislative solutions that would minimize unnecessary burdens.
- **Not finalize its proposal to disallow an E/M visit to be billed for the same patient on the same date as a critical care service when the services are furnished by the same practitioner(s) in the same specialty in the same group.** MGMA believes these are separate services and should be paid as such.
- **Finalize its proposal to change the mandatory Electronic Prescribing for Controlled Substances (EPCS) compliance date from Jan. 1, 2022, to Jan. 1, 2023, for prescribers of controlled substances covered under Medicare Part D, and to implement its proposed exceptions and enforcement actions.** MGMA appreciates the additional time this will afford providers to implement new technologies necessary to comply with this mandate and the necessary flexibility afforded in the exception and individual waiver process for extraordinary circumstances.
- **Not finalize its proposals to amend its authority to terminate, revoke, or deactivate a provider's enrollment in Medicare, including changes that would reduce the total number of factors the agency considers when determining whether to revoke enrollment, including reason for claims denial, as well as a change to shorten the period of time CMS would use to evaluate whether to disenroll a provider from Medicare.** MGMA believes that CMS should instead put forward a program that provides enhanced education, a notification to providers, and a waiting period before CMS revokes Medicare enrollment in situations where improper claims were submitted without nefarious intent due to honest mistakes.
- **Not finalize its proposal to require accountable care organizations (ACOs) in the Medicare Shared Savings Program (MSSP) to report one electronic clinical quality measure/Merit-based Incentive Payment System (MIPS) clinical quality measure (eCQM/MIPS CQM) in performance year 2023 and all three eCQMs/MIPS CQMs in performance year 2024.** MGMA strongly urges CMS to provide ACOs with one additional year, at a minimum, prior to requiring full digital quality measure reporting, permitting the use of the Web Interface as a reporting mechanism through the 2024 performance period and not mandating the reporting of any digital quality measures until 2025, at the earliest.
- **Not finalize its proposal to establish MIPS Value Pathways (MVPs) as the only reporting option under MIPS.** MGMA urges CMS to revert to CY 2021 policy and establish MVPs as an optional pathway in addition to traditional MIPS reporting. We have concerns that as proposed, MVP policy will create additional administrative burdens for practices and silos within the Quality Payment Program (QPP).

- **Not finalize its proposal to implement mandatory subgroup reporting under MVPs beginning in the 2025 MIPS reporting year.** MGMA has always supported voluntary subgroup reporting in MIPS as a flexible option for multi-specialty groups. However, the mandatory subgroup reporting requirement under MVPs will undermine the team-based approach to care and will cause significant administrative burden for practices.
- **Finalize its proposal to implement an automatic extreme and uncontrollable circumstances policy for the 2021 MIPS performance year.** MGMA recommends CMS apply an automatic hardship exception for participants in MIPS for the 2021 performance year, similar to the policy implemented for the 2019 and 2020 performance years.
- **Finalize its proposal to evaluate 2020 quality performance data in order to use historical benchmarks for the 2022 MIPS performance period.** MGMA recognizes that there may be insufficiencies in the 2020 data available due to reporting challenges caused by the COVID-19 pandemic. However, we urge CMS to finalize its policy to use historical benchmarks, data permitting, as it is critical for practices to know what the benchmarks are prior to the beginning of the performance period.

Physician Fee Schedule

Changes in Relative Value Unit (RVU) Impacts

CMS proposal (86 Fed. Reg. 39529): Due to statutory budget neutrality requirements, CMS estimates a CY 2022 conversion factor of 33.5848, which is 3.75% lower than the CY 2021 conversion factor of 34.8931.

MGMA comment: MGMA understands that CMS is constrained by statutory budget neutrality requirements, but nonetheless is deeply concerned about the estimated reduction to the conversion factor for CY 2022. The 3.75% decrease to the conversion factor, paired with the potential effects of Statutory PAYGO and the nearing conclusion of the 2% Medicare sequester moratorium will result in devastating cuts to Medicare reimbursement for CY 2022. MGMA asks CMS to urge Congress to provide a positive update to the Medicare conversion factor in CY 2022 and all future years.

Telehealth

Revised timeframe for consideration of services added to the Medicare telehealth list on a temporary basis

CMS proposal (86 Fed. Reg. 39136): CMS proposes to retain all telehealth services added previously¹ to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023.

MGMA comment: MGMA and our member group practices appreciate the steps CMS has taken to expand remote access to care during the PHE. The addition of 135 codes to the telehealth list on an interim basis has proved a lifeline for certain practices, who can offer expanded services to patients unable to go into the office for an in-person visit.

MGMA supports the proposal to retain all services added to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023. However, as discussed in MGMA's CY 2021 PFS proposed rule comments, we recommend these services be added permanently. Member group

¹ These services were originally added and finalized on a Category 3 basis in the CY 2021 PFS final rule.

practices report that adjusting workflows to operationalize the use of new telehealth codes requires additional resources, such as clinician and staff training and patient education. Removing telehealth services from the covered code list will prove disruptive to both practices and patients alike, as patients have become accustomed to receiving these services virtually.

Instead of removing services after a predetermined or prescriptive date, CMS should permanently add them and let clinicians decide when it is appropriate to furnish such services virtually. Additionally, CMS could permanently add the codes and monitor their utilization to assess impact on program/patient cost and clinical efficacy. MGMA agrees with the strategy behind retaining services added on a Category 3 basis through CY 2023 and believes collecting information regarding utilization of these services during the pandemic is important. However, it is also critical to collect and analyze this data outside of the PHE to get a more comprehensive understanding of how these services are utilized via telehealth. Without knowing exactly when the PHE will end, we suggest permanently adding these services to the telehealth list and propose potentially removing certain services through formal rulemaking when an appropriate amount of time has passed to collect the necessary data.

MGMA recommends that the Category 3 list be expanded to include additional services, particularly the CPT codes for telephone E/M services (99441-99443).

Audio-only visits

CMS proposal (86 Fed. Reg. 39147): In the March 30 COVID-19 interim final rule with comment (IFC), CMS established separate payment for audio-only E/M services (CPT codes 99441-99443) by removing their previous status as “non-covered.” In the CY 2021 PFS final rule, CMS stated that it would not continue to cover and reimburse these services past the conclusion of the PHE. In the CY 2022 PFS proposed rule, CMS proposes to amend its regulation at § 410.78(a)(3) to define “interactive telecommunications system” to include audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients when the originating site is the patient’s home. CMS also proposes to require an in-person visit within six months of each mental health audio-only service.

MGMA comment: MGMA supports CMS’ proposal to amend its regulation to allow for audio-only visits when used for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients when the originating site is the patient’s home. We have long believed that CMS has the authority to modify the definition of “telecommunications system” to allow for audio-only services. However, MGMA encourages CMS to further amend its regulation to include additional services, such as audio-only E/M services (CPT codes 99441-99443).

Throughout the PHE, MGMA has received feedback from group practices on the incredible value of audio-only codes. In an August 2020 poll conducted by MGMA, 82% of respondents reported that they have billed an audio-only service during the PHE.² In 2021, an MGMA member in Oregon reported that 80% of the practice’s virtual visits were audio-only due to much of the population not having access to video capabilities. In many cases, practices try to facilitate a video visit, but due to internet or other technical difficulties, the visit ultimately becomes an audio-only one. An MGMA member from North Carolina reported that in 2020, 68% of her gastroenterology practice’s video visits transitioned to audio-only visits because the video component failed. As expressed in our CY 2021 PFS proposed rule comments, MGMA still believes the following populations could significantly benefit from the ability to utilize audio-only services:

- **Patients with poor broadband access.** For patients who have limited broadband access due

² MGMA poll, Physician Fee Schedule Q&A, Aug. 26, 2020.

to geographic location, audio-only visits may be the only means of accessing care if they cannot go into the office. A 2019 Federal Communications Commission (FCC) report estimates that over 21 million individuals do not have access to broadband.³ Further, researchers have estimated that 41% of Medicare patients lack access to a desktop or laptop computer with a high-speed internet connection at home.⁴

- **Patients who lack access to the requisite equipment to accommodate video functionality.** Audio-only visits provide access to care for patients who do not have adequate equipment to participate in audio *and* visual telehealth visits.
- **Patients with limited digital literacy or access, such as those with low income, limited English proficiency, or other disparities.** Studies have shown that low-income individuals have lower rates of smartphone ownership (71%), home broadband access (59%), Internet use (82%), and basic digital literacy (53%).⁵ Every group practice cares for patients with vulnerabilities that may reduce access to video technology or limit digital literacy. Expanding access to care through reimbursement for audio-only services is one way to mitigate widening gaps in health disparities.

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

In-person visit requirements prior to telehealth and audio-only mental health visits

CMS proposal (86 Fed. Reg. 39145): CMS proposes that an in-person, non-telehealth service must be furnished by the physician or practitioner at least once within six months before each telehealth service furnished for the diagnosis, evaluation, or treatment of mental health disorders by the same practitioner, other than for treatment of a diagnosed substance use disorder or cooccurring mental health disorder, and that the distinction between the telehealth and non-telehealth services must be documented in the patient’s medical record. This proposal applies to both telehealth and audio-only mental health services.

MGMA comment: MGMA does not support the additional six-month in-person requirement. The Consolidated Appropriations Act, 2021 (CAA) included a provision which eliminated the geographic and originating site restrictions for mental health telehealth services. The CAA requires that a patient be seen in person prior to the first mental health telehealth service. However, CMS took this requirement a step further and is proposing that patients be seen within six months of each mental health telehealth visit. We believe CMS should align its policy with congressional intent and the law by only requiring an in-person service before the first mental health telehealth service. This arbitrary six-month requirement will discourage patients from seeking necessary mental health care. CMS should allow treating practitioners to decide when in-person care is appropriate and necessary. If CMS insists upon finalizing this proposal, MGMA asks for a longer interval than six months. CMS could align this policy with the existing policy for an established patient relationship, which would extend the period to three years.

³ [FCC](#), “2019 Broadband Deployment Report,” May 19, 2019.

⁴ Eric T. Roberts, PhD; Ateev Mehrotra, MD, MPH, “Access Among Medicare Beneficiaries and Implications for Telemedicine,” [JAMA Internal Medicine](#), Aug. 3, 2020.

⁵ Sarah Nouri, MD, MPH; Elaine C. Khoong, MD, MS; Courtney R. Lyles, PhD; Leah Karliner, MD, MAS, “Addressing Equity in Telemedicine for Chronic Disease Management During the Covid-19 Pandemic,” [New England Journal of Medicine](#), May 4, 2020 (internal citations omitted).

Appropriate Use Criteria (AUC)

CMS proposal (86 Fed. Reg. 39247): CMS proposes to begin the payment penalty phase of the AUC program on Jan. 1, 2023, or the Jan. 1 that follows the declared end of the COVID-19 PHE, whichever is later.

MGMA comment: MGMA supports CMS' proposal to delay the payment penalty phase of the AUC program until Jan. 1, 2023, or the Jan. 1 following the end of the PHE. As outlined in a [letter](#) to the previous Administration, MGMA is seriously concerned about the AUC program being implemented "as is." The program, created under the Protecting Access to Medicare Act (PAMA) of 2014, is costly and administratively burdensome. According to one estimate, it will cost \$75,000 or more for a practice to implement a clinical decision support mechanism to comply with the AUC program.⁶ Medical groups are at the mercy of third-party vendors, such as electronic health record (EHR) companies, to update their systems within a timely manner. MGMA has heard of instances where vendors are sending alarmist notifications to practices, alerting them that they need to purchase their products immediately to comply. It would be disappointing if the AUC program turned into a money-making enterprise for vendors looking to capitalize on practices merely trying to comply with a government program. In addition to the costs, group practices will have to drastically modify their workflows. Ordering and furnishing providers will need to establish ways to communicate the clinical decision support mechanism consultations to one another, adding to the administrative burden.

Additionally, MGMA urges CMS to use its authority to reduce administrative burdens associated with compliance, including reporting burden. Due to CMS' limited authority on this issue, we encourage CMS to discuss potential legislative solutions with Congress and communicate the specific challenges that it has encountered while trying to implement the AUC program. Many specialties already have their own AUC that they routinely consult to appropriately order tests. We are concerned that this program will disrupt the efficient systems already in place. CMS should also consider exempting medical practices that are already taking on financial risk in alternative payment models (APMs).

Finally, MGMA would like to make CMS aware of the lack of education available for group practices to consult. To our knowledge, CMS has spent little time or resources on educating the physician community about this program. Without further education and outreach campaigns, group practices will have a difficult time preparing for the program regardless of the proposed delay.

E/M Services

Critical care services

CMS proposal (86 Fed. Reg. 39210): CMS proposes that no other E/M visit could be billed for the same patient on the same date as a critical care service when the services are furnished by the same practitioner, or by practitioners in the same specialty in the same group.

MGMA comment: MGMA has serious concerns about CMS' proposal to not allow an E/M visit to be billed for the same patient on the same date as a critical care service when the services are furnished by the same practitioner(s) in the same specialty in the same group. CMS states that it is concerned that allowing critical care and other E/M services to be provided to the same patient on the same date by the same individual will have "unintended consequences." MGMA fails to see any

⁶ Association for Medical Imaging Management; 2017 <https://ahralink.files.wordpress.com/2017/03/cds-survey-2017.pdf>.

major consequences associated with allowing for E/M visits to be billed for the same patient on the same date as a critical care service. It is our understanding that this is not a typical occurrence. For the instances that this does occur, we do not believe medical groups should be penalized and denied payment for the extra time and resources involved. These are in fact separate services and should be paid as such.

Modifiers for split (or shared) visits

CMS proposal (86 Fed. Reg. 39203): CMS proposes to require a modifier to be reported for split (or shared) visits.

MGMA comment: MGMA opposes CMS' proposal to require a modifier to be reported for split (or shared) visits. To require group practices to append modifiers to claims for these services creates unnecessary administrative burden. Moreover, this proposal runs contrary to the changes recently implemented by CMS to alleviate burden for E/M services.

EPCS

Timeframe for EPCS adoption

CMS proposal (86 Fed. Reg. 39329): CMS proposes to change the mandatory EPCS compliance date from Jan. 1, 2022, to Jan. 1, 2023, for prescribers of controlled substances covered under Medicare Part D.

MGMA comment: MGMA supports CMS' proposal to push back the EPCS compliance date by one year from Jan. 1, 2022, to Jan. 1, 2023. While we support the move to EPCS for the various benefits outlined in the proposed rule (i.e., workflow efficiencies, public health improvements, increases in patient safety, fraud reduction, etc.) and encourage practices to adopt EPCS as early as practicable, we also understand the concerns of prescribers having difficulty making the technological upgrades necessary for EPCS due to challenges resulting from the COVID-19 pandemic. Furthermore, we note that each year, more and more states are passing their own e-prescribing laws for controlled substances, and by 2023, most group practices will have these requirements in place at the state level as well. This delay will further decrease the number of prescribers implementing the technology necessary for e-prescribing for the first time. For all of the reasons outlined, MGMA agrees that it is appropriate to delay compliance with this mandate and urges CMS to finalize the new compliance date of Jan. 1, 2023.

Exceptions to and enforcement of the EPCS mandate

CMS proposal (86 Fed. Reg. 39330): In accordance with Section 2003 of the SUPPORT Act, CMS proposes to create the following exceptions to the EPCS mandate:

- (1) Where the prescriber and dispensing pharmacy are the same entity;
- (2) For prescribers who issue 100 or fewer controlled substance prescriptions for Part D drugs per calendar year; and
- (3) For prescribers who are in the geographic area of a natural disaster, a pandemic, or other recognized emergency, or who are granted a waiver based on "extraordinary circumstances", defined as a situation, other than an emergency or disaster, outside of the control of a prescriber that prevents the prescriber from electronically prescribing a controlled substance to a Part D beneficiary.

To meet the standard for a waiver, CMS proposes that prescribers must provide documentation showing the existence of a circumstance beyond their control and that such a circumstance prevents

them from conducting EPCS.

Aside from prescriptions issued while a prescriber is covered by an exception or waiver, CMS proposes that for prescribers to be considered compliant with the EPCS mandate, 70% of their Part D controlled substance prescriptions must be prescribed electronically per calendar year. Once enforcement begins, CMS proposes to enforce compliance by sending letters to prescribers violating the EPCS mandate and seeks comment on further compliance actions.

MGMA comment: MGMA supports the proposed exceptions to the EPCS mandate, particularly the exception for prescribers affected by a pandemic, considering the challenges we have witnessed during the COVID-19 PHE, and those who are granted a waiver based on extraordinary circumstances. We agree with the rationale behind the individual waiver and the flexibility that the waiver process allows.

There are several examples of extraordinary circumstances not explicitly mentioned in the rule, which MGMA believes should be recognized as qualifying extraordinary circumstances in the waiver application process. The first is a documented financial hardship, which would prevent the prescriber and/or their practice from having the financial resources necessary to implement an e-prescribing platform. This is especially necessary as a potential downstream effect of the COVID-19 pandemic. The second is for prescribers in rural or other areas in which pharmacies lack the technological capability to receive and process e-prescriptions. An MGMA member practice with prescribers in rural California indicates that local pharmacies to which they normally send prescriptions for controlled substances do not have the ability to receive e-prescriptions and do not anticipate being able to do so in the near future. It makes little sense for such a medical practice to have to invest in technology for e-prescribing when there isn't a sufficient technological infrastructure present yet in the surrounding pharmacies.

Finally, MGMA supports the CMS proposal not to impose penalties on prescribers that are found to be in violation of the EPCS requirement once the mandate goes into effect. The proposed plan to send a letter to non-compliant prescribers is appropriate for the time being. If CMS chooses in future rulemaking to implement further penalties for non-compliance, we encourage the agency to work closely with the provider stakeholder community to ensure that the proposed penalties are fair and appropriate.

Medicare Provider and Supplier Enrollment Changes

CMS proposal (86 Fed. Reg. 39311): CMS proposes to modify several regulations to enhance its authority to terminate, revoke, or deactivate a provider's or supplier's enrollment in Medicare. Included in these proposals, CMS proposes several revisions to the regulations outlining the agency's ability to revoke enrollment if the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. These proposals would reduce the total number of factors the agency considers when determining whether to revoke enrollment in Medicare. These proposals would also allow CMS to review a shorter period of time during which a significant number of claims were denied.

MGMA Comment: MGMA believes protecting the Medicare Trust Fund from fraud and abuse is paramount and appreciates the concern CMS has in protecting the Medicare program. However, we believe that the right balance must be struck, and any new revisions to Medicare enrollment should not add to the already large administrative burden faced by medical practices trying to comply with Medicare program requirements.

Currently, when determining whether a revocation is appropriate under § 424.535(a)(8)(ii), CMS considers, as appropriate and applicable, the factors outlined in § 424.535(a)(8)(ii)(A) through (F); respectively, these are: (A) The percentage of submitted claims that were denied. (B) The reason(s) for the claim denials. (C) Whether the provider or supplier has any history of final adverse actions and the nature of any such actions. (D) The length of time over which the pattern has continued. (E) How long the provider or supplier has been enrolled in Medicare. (F) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination.

MGMA highlights specifically the proposal to remove the reason for claim denials as a factor under consideration. In the proposed rule, CMS notes that "even if a period of erroneous claim submissions reflected no nefarious intent" the agency would revoke the physician's enrollment due to this short period of erroneous claim submissions. It is our view that in these instances, it is a problem of education, not of punishing bad actors.

Medicare coverage determinations and documentation requirements are constantly changing, and there are instances when a medical practice may submit a batch of claims that, while submitted in earnest, may not adhere to adjusted rules. Additionally, there is variation between Medicare Administrative Contractor (MAC) jurisdictions and local coverage determinations (LCDs). Should a physician move to a different practice under a new MAC and be unaware of new billing requirements, the physician would be penalized under this proposal while not having any nefarious intent toward the Medicare program. It is our belief that education and a resubmission of claims is the proper course in these instances.

The previous scenario, combined with the other CMS proposal to shorten the time period the agency uses to examine when determining whether to disenroll a provider from the Medicare program, will create a problematic situation for overburdened physicians in medical practices that are trying to provide essential services to Medicare beneficiaries during a pandemic. MGMA is very concerned that these proposals, when taken together, will disadvantage solo and small practices with few administrative resources, particularly those that reside in rural and other underserved communities. MGMA urges CMS not to finalize these proposals and instead put forward a program for enhanced education, notification, and a waiting period before CMS revokes Medicare enrollment in situations where improper claims were submitted without nefarious intent due to honest mistakes.

MSSP

MSSP: ACO quality reporting requirements

CMS proposal (86 Fed. Reg. 39267): CMS proposes to extend the CMS Web Interface as a collection type for an additional two years through performance years 2022 and 2023 for MSSP accountable care organizations (ACOs) reporting via the APM Performance Pathway (APP).

For performance year 2022, CMS proposes that an ACO would either be required to report on the 10 Web Interface measures or the three electronic clinical quality measures/MIPS clinical quality measures (eCQMs/MIPS CQMs), along with the CAHPS for MIPS survey measure and the two administrative claims-based measures in the calculation of the ACO's quality performance score.

For performance year 2023, CMS proposes that an ACO would either be required to report the 10 CMS Web Interface measures and at least one eCQM/MIPS CQM *or* the three eCQMs/MIPS CQMs, along with the CAHPS for MIPS survey measure and the two administrative claims-based measures.

MGMA comment: MGMA appreciates the proposal to extend the Web Interface as a quality

reporting mechanism for an additional two performance years. We believe this will provide necessary flexibility for ACOs as they make the transition from reporting via the Web Interface to digital quality measures, noting that such a transition takes a significant amount of time, consideration, and resources. Reporting digital quality measures will require ACOs to make changes to operational workflows, secure new technologic capabilities, and familiarize themselves with reconfigured measure sets, all of which require the attention of dedicated staff as well as an upfront financial investment for EHR upgrades. For this reason, we are concerned that mandatory reporting of at least one eCQM/MIPS CQM for performance year 2023 and three eCQMs/MIPS CQMs for performance year 2024 does not allow ACOs a long enough transition period to satisfy these reporting requirements. We strongly urge CMS to provide ACOs with one additional year, at a minimum, prior to requiring full eCQM reporting, permitting the use of the Web Interface as a reporting mechanism through the 2024 performance period and not mandating the reporting of any digital quality measures until 2025.

ACOs moving to CQM or eCQM may encounter technical difficulties and data-sharing limitations that arise from a lack of interoperability. ACOs often consist of several group practice TINs that all work together to achieve the goals of the ACO and the program. This entails coordination across multiple practice sites, which may utilize several different EHRs, and for some of our members in ACOs, upwards of a dozen different systems. For an ACO that uses multiple systems, the shift away from Web Interface to CQM or eCQM may require additional capabilities to enable reporting, such as retention of a separate third-party vendor to aggregate patient data across these systems or added functionalities to existing products. This involves not only added expenses but also learning and implementing new workflows. ACOs and their participant groups need time to make these changes and secure appropriate vendors and/or added technological capabilities within their current systems. This problem is further exacerbated by the fact that within the vendor community, there are not enough technology solutions and resources available to help ACO participants with this data aggregation.

While we believe that the advancement toward a fully digital measure set is a necessary and worthwhile investment for the healthcare field, we caution CMS from mandating that this transition take place too quickly. The health information technology infrastructure is simply not yet mature enough across the majority of medical group practices in order to progress to this level of interoperability within the next year and a half. ACOs should be afforded additional time to consider all available options and choose the best and most cost-effective one, rather than being forced to rush into a contract that may not be the best fit but offers the quickest solution for the sole purpose of meeting this mandate.

Additionally, we emphasize that the upfront cost of making such technological upgrades is prohibitive, particularly in the current environment. One MGMA member practice that is part of a modestly sized ACO of approximately 15,000 assigned beneficiaries put out a request for proposals to migrate to all-payer digital measure reporting in 2021 and found that among the most conservative estimates, their reporting costs would increase by five to six times annually. If CMS would like to promote a swifter advancement towards all-payer digital quality measures, MGMA recommends that CMS offer new funding opportunities to support group practices in making this transition. To avoid losing program participants, especially as healthcare entities face financial uncertainty as a result of the COVID-19 pandemic, CMS should consider new opportunities to offer upfront funding to ACOs making technological upgrades to meet the program's quality reporting requirements.

Finally, we assert that the upfront technological challenges and costs associated with reporting one eCQM is not substantially different from those associated with reporting three eCQMs. We understand that the mandatory reporting of one eCQM/MIPS CQM in performance year 2023 is

intended to provide a gradual on-ramp for ACOs making the transition to report digital quality measures. However, we argue it would essentially require the same level of effort to aggregate the necessary data across all EHRs and taxpayer identification numbers (TINs) within a given ACO to be able to report one eCQM as it would for three eCQMs. This problem is further exacerbated the more there are different EHR platforms, or separate instances of the same EHR, across various ACO participating providers.

Therefore, we do not believe this proposal will achieve its intended result and will instead shorten the amount of time that ACOs have to make the necessary upgrades for digital quality measure reporting. Instead, MGMA encourages CMS to maintain the same ACO quality reporting options for performance years 2022 through 2024 and to incentivize the transition to eCQMs/MIPS CQMs during this period through the implementation of more favorable quality performance standard requirements for ACOs reporting eCQMs/MIPS CQMs, as it has proposed. MGMA strongly recommends that no eCQM reporting be made mandatory for ACOs before performance year 2025, at the earliest.

MSSP: Retaining a pay-for-reporting year for new ACOs

CMS proposal (86 Fed. Reg. 39268): For the first performance year of an ACO's first agreement period under the Shared Savings Program, if the ACO meets MIPS data completeness and case minimum requirements CMS proposes that the ACO would meet the quality performance standard. This continues the current policy of providing all new ACOs with a pay-for-reporting year at the start of their contract.

MGMA comment: MGMA appreciates the CMS proposal to allow for a pay-for-reporting year for new ACO participants. However, we are dismayed that CMS has chosen not to continue the pay-for-reporting policy previously applied when measures were newly introduced, were modified mid-performance period, or had no benchmark. In the 2021 PFS final rule, CMS removed this prior policy and finalized a new policy for 2021 and beyond that would suppress such measures from the APP measure set instead of giving full credit to entities reporting those measures.

Within this new measure suppression policy, it is possible that ACOs will be held accountable for fewer than three clinical quality measures under the APP in cases where one or more eCQMs are new, undergo modifications, or lack benchmarks. In this scenario, the ACO's performance and therefore its shared savings would become even more dependent on just a few measures. This has the potential to greatly skew the ACO's performance in unanticipated and unfair ways. Implementing a pay-for-reporting policy in response to new measures or measures undergoing significant modifications would ensure there are no unintended consequences before holding an ACO accountable for performance on the measure. Pay-for-performance years for new and modified measures allow time for ACOs to assess technical, clinical, and operational changes before they are held accountable for performance on such measures. This, therefore, allows ACOs to be successful in getting credit for the quality improvement work they are doing, since the way quality data are captured for new measures is often just as important as the quality data themselves.

MSSP: All-payer data collection and reporting

CMS proposal (86 Fed. Reg. 39270): CMS solicits comments on the feasibility of TIN-level reporting and sampling for eCQMs/MIPS CQMs, in particular the requirement to report on all-payer data rather than data specific to the ACO's population of assigned beneficiaries.

MGMA comment: MGMA appreciates that CMS recognizes the challenges associated with all-payer data reporting. While MGMA understands the agency's reasoning for transitioning to all-payer quality measures, we do not believe that such reporting is appropriate for the MSSP. MGMA

respectfully requests that CMS remove the all-payer requirement for ACOs reporting eCQMs via the APP and instead implement a sampling methodology focused only on the ACO's assigned beneficiaries meeting the denominator criteria for a given measure. We assert that a sampling methodology focused on ACO assigned patients is fairer, more accurate, and more consistent with the statutory intent of the program.

We believe that an ACO should be evaluated on its assigned beneficiaries only, rather than all patients, regardless of payer, that meet measure denominator criteria. Putting ACOs' shared savings at risk for non-Medicare patients is not the statutory intent of the MSSP. It would be both inappropriate and unreasonable to measure ACO quality using non-ACO and non-Medicare patients. We understand if CMS would like to capture these data, but at a minimum, ACOs should not be held accountable for non-ACO assigned patients in the calculation of their quality scores. For these reasons, MGMA recommends that CMS remove its all-payer reporting requirement for eCQMs.

MSSP: ACO quality performance standard

CMS proposal (86 Fed. Reg. 39272): CMS proposes an additional one-year freeze before phasing in an increase to the quality performance standard in performance year 2023, which ACOs must meet to share in savings.

The quality performance standard will remain at the 30th percentile MIPS quality performance category score for both performance year 2022 and performance year 2023 to determine shared savings and losses. Instead, CMS proposes a revision in the quality performance standard to encourage ACOs to report all-payer measures in performance years 2022 and 2023. For ACOs reporting all three eCQMs/MIP CQMs in the APP, CMS specifies that the ACO will satisfy the quality performance standard if the quality score is equal to or greater than the 30th percentile on at least one measure in the APP measure set.

In performance year 2024, CMS proposes to increase the threshold for the quality performance standard to the 40th percentile MIPS quality performance category score.

MGMA comment: While MGMA appreciates CMS' proposal to provide ACOs additional time before increasing the quality performance standard, we do not believe that comparing ACO quality performance to MIPS quality performance is appropriate to begin with. We recommend that CMS revert to its previous method for evaluating the MSSP quality performance, the minimum attainment standard.

It is unfair to compare ACOs' quality performance to MIPS quality performance standards. MIPS-eligible clinicians and groups have the ability to hand-select the quality measures for which they believe they can achieve the highest score, whereas ACOs must report on a pre-selected measure set. This does not create a level playing field and unfairly disadvantages ACOs that must report on measures that are not necessarily clinically relevant to their providers. Therefore, we assert that determining an ACO's shared savings or losses by comparing it to all MIPS final quality category scores is not only inappropriate, but counter to the intent of the program to advance the provision of medicine toward value-based payment and away from traditional fee-for-service.

If CMS chooses not to make the recommended changes to the ACO quality performance standard and instead continues comparing MSSP quality assessments with MIPS quality assessments, we request that CMS not finalize an increase to the threshold for the quality performance standard in the same year that it intends to sunset the Web Interface. This would introduce too much variability and unpredictability in performance year 2024 as currently proposed. Therefore, if CMS finalizes a full transition to mandatory eCQM reporting for performance year 2024, we recommend the agency maintain the 30th percentile performance standard for that year.

MSSP: Calculation of the regional adjustment and updating benchmarks for ACOs

CMS proposal (86 Fed. Reg. 39291): CMS seeks comment on the calculation of the regional adjustment and blended national-regional growth rates for trending and updating benchmarks for ACOs in the MSSP. CMS does not propose any changes to the program’s benchmarking methodology, but rather seeks input on potential approaches for removing an ACO’s assigned beneficiaries from the assignable beneficiary population used in regional expenditure calculations.

MGMA comment: MGMA appreciates that CMS is soliciting comments on this topic, given we have engaged in advocacy related to fixing a flaw in the calculation of the regional adjustment and regional inflation for several years. While we have endorsed legislation aimed at fixing this flaw, referred to as the “rural glitch”, we believe that it is fully within CMS’ authority to fix this issue through rulemaking.

The solution to fix the “rural glitch” is as simple as removing ACO-assigned beneficiaries from the regional reference population. This solution would create a fairer and more accurate benchmark for ACOs and appropriately reward ACOs through savings when they improve quality and reduce costs. Currently, when an ACO lowers the total cost of care for its assigned beneficiaries, it also reduces the average regional costs, which diminishes the positive effect of the regional adjustment. In this way, the ACO is being penalized for reducing costs among its own beneficiaries.

If CMS were to remove ACO assigned beneficiaries from the regional reference population, it would stop comparing an ACO’s performance to itself and fix this problem altogether. While CMS acknowledges the positive effect this change would have on many ACOs, the agency expresses concern about the negative effect it can have on others. Research conducted by our colleagues at the National Association of ACOs (NAACOS) in 2020 indicated that 80% of MSSP ACOs would benefit from removing ACO-assigned beneficiaries from the regional reference population. Therefore, the potential negative consequences of correcting this flaw seem far less concerning than the actual flaw itself, given the vast majority of ACOs stand to see improvements as a result of the recommended fix.

We urge CMS to make the formal regulatory changes necessary to remove ACO-assigned beneficiaries from the regional reference population and thereby fix the rural glitch without delay. Fixing this issue is vital to creating a level playing field for ACOs and rewarding ACOs with the savings they deserve when they improve quality and reduce costs.

QPP: MIPS and APMs

MIPS Value Pathways (MVPs)

MVPs: Implementation timeline

CMS proposal (86 Fed. Reg. 39355): CMS proposes an implementation timeline for eligible clinicians to begin reporting under MIPS via MVPs. Beginning with the 2023 performance year, MIPS clinicians have the option to voluntarily report via one of the seven proposed MVPs. The proposed MVPs focus on different specialties, patient populations, or clinical diagnoses. As proposed, during the CY 2023 and 2024 performance years, individual MIPS clinicians, single specialty groups, multispecialty groups, subgroups, and APM entities are eligible to report under an MVP. Beginning in 2025, groups would be required for form subgroups in order to report under an MVP.

MGMA comment: MGMA supports CMS’ efforts to create a program intended to make MIPS more clinically relevant and less burdensome, streamline the four performance categories, and create a

pathway to Advanced APM participation. As group practices continue to fight on the frontlines of the COVID-19 pandemic, we appreciate that CMS proposed to implement the MVP reporting option beginning in CY 2023. This timeline will provide practices with enough time to evaluate the currently proposed MVPs, evaluate current workflows, and determine whether or not to participate during the first MVP performance year.

As a mechanism to ensure successful participation in MVPs, MGMA recommends CMS implement a more gradual transition to reporting under MVPs. CMS should hold clinicians harmless from a payment penalty for the first two years that MVPs are introduced into the program and apply this policy to new MVPs as they are introduced. MVPs are designed to create more clinically appropriate reporting pathways for practices; as such, there will not be many MVPs that apply to different practice types in the early years of the program. It will be critical for CMS to provide on-ramps into MVP reporting for clinicians of different specialties. For example, the currently proposed seven MVPs may not apply directly to a radiology practice that reports under MIPS. As CMS continues to collaborate with stakeholders to develop an applicable MVP, the radiology practice may not have the opportunity to report under the appropriate MVP during an on-ramp period during which CMS holds clinicians harmless from payment penalties.

MGMA appreciates CMS' focus and response to concerns with current MIPS reporting and scoring policies and the ongoing development of the MVP reporting option. We encourage CMS to continue evaluating the effectiveness of MVPs as an alternative approach to MIPS as the program is introduced and the first year of performance results are evaluated.

MVPs: Sunsetting traditional MIPS

CMS proposal (86 Fed. Reg. 39356): CMS requests feedback on a potential timeline transitioning from traditional MIPS to fully implementing and requiring reporting through an MVP for participation in MIPS. The agency discusses the potential to sunset traditional MIPS after the 2027 performance year and transition to full MVP reporting beginning in the 2028 performance period.

MGMA comment: We appreciate the agency's continued collaboration with stakeholders to continue refining and developing a quality reporting pathway under MIPS that effectively evaluates quality of care and incentivizes practices to continue providing improved care to patients. MGMA has worked continuously with CMS to refine and implement improvements to the QPP to reduce administrative burdens and create an effective incentive program to reward practices for high quality care.

In the CY 2021 Medicare PFS preamble, the agency stated that CMS "envisi[on]s that MVPs will be optional"⁷ and clinicians will still be able to report under traditional MIPS based on which reporting option is more feasible and has the most meaningful measures applicable to a practice. MGMA recommends CMS ensure MVPs are an optional reporting pathway and caution the agency not formally propose to sunset traditional MIPS. We have concerns that the MVP framework will create silos in the QPP, undermining efforts of team-based approaches to care.

MVPs: Subgroup Reporting

CMS proposal (86 Fed. Reg. 39357): Beginning with the 2025 performance year, CMS proposes to require multi-specialty groups to form subgroups in order to report under an MVP.

MGMA comment: We appreciate CMS' concern that large multi-specialty groups reporting under a single MVP may not have included measures that are meaningful to every clinician in the group.

⁷ The Centers for Medicare & Medicaid Services CY 2021 Medicare Physician Fee Schedule Proposed Rule, CMS-1734-P. ([85 Fed. Reg. 50279](#)).

However, MGMA has generally opposed subgroup reporting in the context of historical quality reporting programs due to concerns that partitioning practices into subgroups could undermine the efficiencies and advantages of the group practice model. CMS should maintain subgroup reporting as an optional pathway under MVPs and should encourage subgroups be composed of clinicians of multiple specialties, as appropriate, to encourage team-based care.

MGMA also has concerns about the timing of implementing subgroup reporting requirements. As proposed, CMS will require all multi-specialty groups form subgroups in order to report under an MVP beginning in 2025. This creates significant burdens for multi-specialty groups that will not have an appropriate MVP to report during the first two years of the program. These groups will not be afforded the opportunity to participate via an MVP during the first two years of the program with the additional flexibilities of multi-specialty group reporting.

Further, subgroup reporting will increase reporting burden and complexities for group practices that are required to form multiple subgroups and report on multiple MVPs. If finalized as proposed, multi-specialty groups will be required to report on a greater number of quality measures, compared with current MIPS policy.

CMS proposal (86 Fed. Reg. 39362): CMS does not propose to establish required criteria for subgroup composition and seeks feedback from stakeholders on whether it would be appropriate to establish requirements limiting subgroups to a single specialty, limiting the size of a subgroup, or creating criteria related to scope of practice, patient population, or practice location.

MGMA comment: MGMA is uniquely positioned to provide comments on the operational concerns and administrative issues related to subgroup reporting under MIPS and the new MVP reporting option. MGMA believes that CMS should not be prescriptive in how subgroups are formed. Specifically, requiring subgroups be composed of single specialties will undermine the CMS established approach to developing MVPs. In the proposed rule, CMS outlines the three different approaches for developing and evaluating MVP development and participation, one of which is to “structure MVPs in a manner that reflects a team-based healthcare model” (86 Fed. Reg. 39367). The agency further outlines such an MVP as one that involves multiple different clinician types. MGMA believes that such MVPs that champion team-based approaches to care can effectively and appropriately evaluate the quality of care provided by multi-specialty groups and align with agency goals to improve care coordination and patient-centered care.

CMS proposal (86 Fed. Reg. 39365): CMS proposes to delay the public reporting of subgroup performance data by one calendar year. Beginning with the 2024 performance year, CMS will publicly release subgroup-level performance data on the CMS Care Compare tool.

MGMA comment: We appreciate CMS providing clinicians with additional flexibilities during the initial implementation of MVPs. The one-year delay in public reporting will provide practices with the opportunity to improve performance under the new MIPS pathway. However, we would encourage CMS to create additional flexibilities for public reporting of subgroups for at least the first three years of optional reporting under MVPs.

CMS estimates that only 10% of MIPS eligible clinicians will report under MVPs during the 2023 performance year, and even fewer will report as a subgroup. To incentivize greater participation in MVPs during the initial implementation period and to ensure clinicians have the opportunity to report under an applicable MVP as they continue to be developed, we recommend CMS re-evaluate the public reporting policy for subgroups under MVPs.

Merit-based Incentive Payment System (MIPS)

MIPS: Automatic Extreme and Uncontrollable Circumstances Hardship Exception for 2021 Performance Period

CMS proposal (86 Fed. Reg. 39450): CMS proposes clarifications to how the application-based and automatic extreme and uncontrollable circumstances policy for reweighting of performance categories in MIPS for clinicians impacted by extreme and uncontrollable circumstances as identified by CMS.

MGMA comment: While we experienced a reduction in COVID-19 cases earlier in 2021, recent surges in cases as a result of the Delta variant have once again put immense pressure on practices, and we expect the coronavirus will continue to significantly impact the healthcare system throughout 2021. Continued flexibility is needed to support medical groups and avoid creating additional burden, such as a requirement to submit a hardship application. MGMA recommends CMS implement an automatic hardship exception for participants in MIPS for the 2021 performance year, similar to the policy implemented for the 2019 and 2020 performance years.

MIPS Quality Performance Category

MIPS: Quality measure benchmarks

CMS proposal (86 Fed. Reg. 39431): Generally, CMS uses historical benchmarks to score quality measures based on performance data gathered two years before the performance year. For the 2022 performance period, CMS proposes to first evaluate the data completeness of 2020 performance data. However, if there is insufficient data to calculate historical benchmarks due to flexibilities in reporting during the COVID-19 pandemic, CMS proposes to use 2022 performance period benchmarks to score quality measures.

MGMA comment: MGMA appreciates CMS' forethought that 2020 benchmarks may be unreliable or skewed due to the COVID-19 pandemic. However, we have concerns about using current year (2022) performance data to formulate quality benchmarks. Establishing benchmarks that are stable, reliable, and valid is critical and will better ensure that clinicians are able to engage in a meaningful and useful way. We believe clinicians and group practices should have time to understand how their performance compares to benchmarks and to adjust performance based on these comparisons. We recommend that CMS carefully review 2020 data to determine whether or not it could be used to calculate valid historic benchmarks before moving forward with its proposed policy to use 2022 benchmark data.

CMS proposal (86 Fed. Reg. 39435): The agency proposes to modify the "topped out" quality measure policy for the 2022 performance year in the likelihood that the agency will have insufficient data to calculate historical benchmarks and be required to use performance period benchmarks. CMS proposes that MIPS clinicians will not receive more than seven points for topped out measures if they are determined to be topped out for two consecutive years based on 2021 historical data and are again topped out based on 2022 performance data.

MGMA comment: While MGMA has expressed concerns about the proposal to use performance period benchmarks for the 2022 performance period, we appreciate the agency's forethought to provide clinicians with additional information determining which measures are topped out prior to the performance period. MGMA recommends CMS finalize this policy to ensure that clinicians can select meaningful measures and earn maximum points on quality measures due to the extraordinary

circumstances of the COVID-19 pandemic.

MIPS: Removing quality measures

CMS proposal (86 Fed. Reg. 39392): CMS proposes to remove 19 measures due to low adoption, topped out status, or potential duplication.

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

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

When CMS removes a measure from the quality inventory, it must engage in a comprehensive education and outreach campaign to provide sufficient notice to physician group practices. In addition to labeling extremely topped out measures in all measure appearances, including on the QPP website and in the benchmark spreadsheet, CMS should notify physicians and groups in their feedback reports about whether any of the measures they submitted have been deemed extremely topped out. We urge CMS to work with data submission vendors to provide feedback to group practices that select extremely topped out measures and to provide feedback in the remittance advice to clinicians who submit data about an extremely topped out measure via claims.

MIPS Improvement Activities Performance Category

MIPS: Extension of COVID-19 Clinical Trial Improvement Activity

CMS proposal (86 Fed. Reg. 39409): CMS proposes to extend the COVID-19 Clinical Data Reporting With or Without Clinical Trial improvement activity for the CY 2022 performance year and continue to assess the appropriateness of maintaining this measure in future rulemaking cycles.

MGMA comment: MGMA appreciated CMS' swift action to establish the high-weighted activity for participation in COVID-19 clinical trials during the 2021 performance period. We agree with the agency that this measure incentivizes clinicians to participate in COVID-19 related efforts. We urge CMS to continue to extend the improvement activity as long as appropriate.

MIPS Promoting Interoperability (PI) Performance Category

MIPS: Maintaining 90-day Performance Period for PI Measures

CMS proposal (86 Fed. Reg. 39409): In the CY 2021 Medicare PFS final rule, CMS finalized a policy to maintain the 90-day reporting period for the PI performance category beginning in the 2022 performance year and all subsequent MIPS performance years. CMS does not propose any updates to the reporting period for the PI performance category.

MGMA comment: We appreciate CMS maintaining the 90-day reporting period for the PI performance category and encourage CMS to maintain the 90-day reporting period for future performance years. By providing continued program stability, CMS allows clinicians and practice groups to focus on providing high quality care to patients and less time on overburdensome reporting requirements.

MIPS Final Score and Payment Adjustments

MIPS: Performance Threshold

CMS proposal (86 Fed. Reg. 39452): In accordance with statute, CMS is required to establish the performance threshold for MIPS using the prior year's mean or median beginning in CY 2022. CMS proposes to establish the performance threshold for neutral payment adjustment under MIPS at 75 points for the 2022 performance year/2024 payment year.

MGMA comment: We recognize the statutory requirement to fully implement MIPS performance thresholds beginning in 2022; however, we strongly urge CMS to leverage their authority to reduce the performance threshold due to the impact of the COVID-19 pandemic.

Prior to the pandemic, the MIPS performance threshold was 30 points (2019 performance year/2021 payment year). If the proposed policy is implemented, this threshold will have more than doubled to 75 points beginning in 2022. Our member group practices report that they continue to divert energy and resources toward battling the COVID-19 pandemic. Many leveraged the extreme and uncontrollable circumstances policy in 2020 and may be again required to leverage similar flexibilities in 2021. Assuming these groups are able to participate in MIPS in 2022, they will be subject to significantly more stringent reporting requirements than they encountered in 2019, the last year they were able to focus on MIPS reporting. To continue CMS' policy of gradually increasing MIPS reporting requirements each year, and in recognition of the disruptions caused by COVID-19 in 2020, we encourage the agency to extend the 2021 reporting threshold through the 2022 performance year.

MGMA also has significant concerns with the CMS estimates that only 67.5% of MIPS eligible clinicians will receive a positive or neutral payment adjustment during the 2024 payment year if the MIPS policies are implemented as proposed. Reporting under MIPS requires significant time and financial investment among our member group practices, diverting critical resources away from practices protecting patients on the frontline of the pandemic. We encourage CMS to revisit proposed policies related to MIPS reporting in 2022 to ensure that practices have the opportunity to meaningfully participate in MIPS without fear of significant financial impact as the nation continues to recover from the COVID-19 pandemic.

APM Performance Pathway (APP)

CMS proposal (86 Fed. Reg. 39388): To create stability within the APP, CMS does not propose any changes to the APP for performance year 2022. The APP is intended to provide a predictable and consistent MIPS reporting option to reduce reporting burden and encourage continued APM participation.

MGMA comment: MGMA appreciates that CMS intends to provide stability to APM entities reporting via the APP by not proposing any significant changes to the APP for the upcoming performance year. This is a welcome proposal, given no MIPS APMs have yet completed reporting via the APP for the first performance year of its existence in 2021, and we therefore do not have

feedback from them on the process or any related concerns. We also appreciate the resources that CMS recently released to help MIPS APMs better understand the reporting and scoring processes as they evaluate reporting via the APP for the first time.

However, we still have concerns about the use of the APP as a scoring standard for MIPS APMs, particularly those outside of the MSSP. As discussed in MGMA's CY 2021 PFS proposed rule comments, we are concerned that the APP quality measure set requires that all MIPS APMs report the same measures, regardless of the model's specialty focus. This policy is counter to CMS' goals in other areas of the program, such as MVPs and specialty measure sets, to make MIPS more clinically relevant to specialists. In contrast to the APP, the previous MIPS APM scoring standard recognized that each APM has its own set of unique quality measures and scoring policies. Additionally, for MIPS APMs other than MSSP participants, reporting via the APP would require an APM to submit two separate quality measure sets: one for their own model evaluation and a second set of APP measures for MIPS. This increases administrative burden for MIPS APMs that would then have to report both.

We recognize that under the CMS policy finalized in the 2021 PFS rule, APMs could forgo reporting via the APP and instead report under traditional MIPS, thereby enabling them to select potentially more relevant quality measures from the traditional MIPS inventory. However, subjecting APMs to traditional MIPS scoring policies does not recognize the work APM participants do within their own model to further cost-efficient, coordinated care. Specifically, choosing to report for traditional MIPS would subject APM participants to measurement on cost category measures, while concurrently holding them accountable for cost benchmarks or reduction efforts that are inherent goals of their model; it would also entail submission of improvement activities, rather than affording them automatic credit as it had previously. MGMA believes that this is counter to the agency's mission to promote APM participation.

While the APP quality measures may be clinically relevant to ACOs and primary-care focused APMs, they are not relevant to specialty-focused APMs, such as participants in the Bundled Payments for Care Improvement Advanced (BPCI-A) model. Furthermore, many such model participants have never administered CAHPS surveys before and doing so now would require added expenses and changes to patient workflows. Requiring practices in BPCI-A that do not achieve qualifying participant (QP) status to report either the APP measure set, which includes primary care-focused measures they are not familiar with, or the traditional MIPS scoring standard is unfair and is not moving the Quality Payment Program (QPP) in the right direction.

We further submit that episodic, specialty-focused models, such as BPCI-A and Comprehensive Care for Joint Replacement (CJR), have generally been required to report for MIPS, based on our review of available data and anecdotal feedback from past performance years, rather than enjoy the benefits of the Advanced APM track, due to existing policies around attaining QP status that make it exceedingly difficult for them to achieve even partial QP status. We learned from members in BPCI-A and CJR that they have not achieved even *partial* QP thresholds in past years, meaning they must report for MIPS or face a payment penalty. The QPP Experience Reports released to date confirm these anecdotal reports concerning low QP thresholds, at least with respect to the CJR model (since BPCI-A data was not included in any report to date): in each year, aggregate results show the average payment threshold has not exceeded 13% and average patient threshold was just 5% in both years.⁸ Therefore, until QP threshold policies can be fixed, we urge CMS to put additional thought into how to make the MIPS program more meaningful to these practices, rather than disadvantaging them and

⁸ 2017 QPP Experience Report, Table 7; 2018 QPP Experience Report, Table 7.

failing to recognize their work through the APM toward furthering high quality, cost-effective care.

Finally, as an overarching recommendation and in light of the concerns outlined above, we encourage CMS to consider how to move more APM participants away from MIPS altogether and into the Advanced APM track of the QPP, as was Congress's intent when enacting MACRA. For example, CMS could modify its financial risk standard to allow more APMs to meet the definition of an Advanced APM and modify its policies around QP thresholds to add more flexibility into the patient count threshold, as is permitted by MACRA. We fear that increasing QP thresholds to unachievable levels combined with clinically inappropriate quality reporting via the APP and/or additional category requirements associated with reporting via traditional MIPS are starting to disincentivize participation in Advanced APMs. The lack of appropriate incentives and misalignment of reporting priorities should not stand in the way of the Administration's efforts to encourage providers to engage in value-based care initiatives through its portfolio of available APMs.

Conclusion

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

Sincerely,

/s/

Anders Gilberg

Senior Vice President, Government Affairs