



August 21, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-P
P.O. Box 8013
Baltimore, MD 21244-8013

File Code: CMS-5522-P

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

Dear Ms. Verma:

The Healthcare Financial Management Association (HFMA) would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the issues discussed in the Medicare Program; CY 2018 Updates to the Quality Payment Program, published in the June 30, 2017, *Federal Register*.

HFMA is a professional organization of more than 38,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry.

Introduction

HFMA would like to commend CMS for its thorough analysis and discussion of the myriad Medicare physician reimbursement decisions addressed in the Quality Payment Program (QPP) Proposed Rule. As an organization, HFMA fully supports the transition to outcomes-based payment. Our members see this as crucial to efforts to improve the value of care delivered. To help our members successfully lead their organizations through this complex transition, we continue to publish the best practices of leading organizations through our Value Project research.¹

HFMA's members have specific concerns and questions regarding the proposals related to the following:

- Merit-Based Incentive Program (MIPS)
 - Increased Flexibility
 - Patient Complexity Adjustment
 - Definition of a Group Practice - Split Reporting TINs (Taxpayer Identification Numbers)
 - Improvement Bonus Methodology

¹ Healthcare Financial Management Association. 2015. *The Value Project Sourcebook*.
www.hfma.org/valueproject/valuesourcebook/

- Advanced Alternative Payment Model (AAPM) Incentive
 - Availability of AAPM Models
 - “All-Payer Option” Administrative Burden

- Opportunities for Administrative Simplification
 - Necessary Changes to the Fraud and Abuse Regulations
 - Aligning Meaningful Use Across Programs and Care Delivery Settings
 - Improving Quality and Cost Measures
 - Supporting Physician Practices

Below please find specific comments on the items listed above.

Merit-Based Incentive Payment System (MIPS)

Increased Flexibility: HFMA generally supports the concept of providing clinicians who are subject to the QPP maximum flexibility. We believe this is necessary, particularly in the early years, as CMS establishes the program, providers refine their capabilities to participate and submit data, and electronic health record (EHR)vendors adapt their products to support clinician participation.

Low-Volume Exclusions for Small Practices: CMS finalized a low-volume exclusion for individual MIPS-eligible clinicians or groups with \$30,000 or less in Medicare billings or providing care for less than 100 Part B beneficiaries for the 2017 MIPS performance year (2019 payment year). If finalized, the rule proposes to expand the exclusion to individual clinicians or groups with Medicare billed charges less than or equal to \$90,000 or providing care for 200 or fewer Part B-enrolled Medicare beneficiaries. The proposed rule states that, if finalized, approximately 585,000 clinicians would be excluded under the low-volume threshold for payment year 2020. This is greater than the number of physicians who are projected to receive a MIPS score that year (approximately 572,000).

HFMA cautiously supports the expanded exclusion. Given the considerable expense and administrative burden required to participate in the MIPS program, we believe it is necessary to provide smaller practices increased flexibility. However, we are concerned about the message this sends longer term. First, there will be practices who were compelled to participate in year one that are now excluded. Many smaller practices have made necessary investments to meet the requirements and now this exclusion could blunt the momentum for continued practice. **Therefore, we ask that CMS allow voluntary participants to receive positive payments if they are eligible for them to reward them for their investments.** Otherwise, HFMA is concerned that the proposed expansion of the exclusion will penalize progressive practices. It is also likely that the uncertainty will further stall investments by small practices (and the vendors that support them) in the infrastructure and capabilities necessary to successfully participate in MIPS. To mitigate this unintended consequence, HFMA asks CMS in the final rule to delineate an “exclusion roadmap” that describes when practices of varying sizes will be subject to MIPS.

Required Submission of 12 Months of Quality Data: For the 2017 performance year (2019 payment year), CMS finalized a minimum 90-day performance period for the quality, advancing care information, and

cost categories. The proposed rule would expand that to 12-month calendar reporting for the 2018 performance year (2020 payment year).

While HFMA's members believe that full-year reporting will likely result in more accurate results due to a larger sample size, we believe this move is premature. Our members remain concerned about the ability of some EHR vendors to support this capability. **Therefore, we believe CMS should leave the current minimum 90-day performance period for quality and cost measures unchanged.**

Cost Performance Category: For the 2017 performance year (2020 payment year), CMS finalized a weight of 0 percent for the cost performance category. For the 2018 performance year, CMS proposes to leave it weighted 0 percent. CMS cites its concerns about clinicians' understanding of the cost measures and plans to use 2018 for outreach to clinicians. HFMA's members believe CMS's concerns are valid (please see the discussion below on "Improving Cost and Quality Measures" in the Administrative Simplification section of the letter). **Despite this, HFMA's members believe the cost performance category should be weighted at 10 percent.** CMS is statutorily required to weight the cost performance category at 30 percent for the 2019 performance year (2021 payment year). We believe that moving from a 0 to 30 percent weighting for the cost performance category is too steep a ramp. Also, we are concerned that without the cost category having some impact on overall MIPS performance, physician practices will continue to overlook it, given its complexity and physicians' focus on the quality category, which is much higher weighted. In allocating 10 percentage points to the cost performance category, HFMA's members believe CMS should reduce the weight of the quality performance category to 50 percentage points.

Patient Complexity Adjustment: HFMA's members appreciate CMS's discussion and proposals related to adjusting the MIPS score to recognize the challenges faced by physicians caring for complex populations and/or populations facing significant socioeconomic challenges. As discussed below, we are generally supportive of the proposal to include a bonus based on Hierarchical Condition Category (HCC) score and would encourage CMS to add a separate bonus based on the percentage of dual-eligible patients.

HCC-Based Complexity Bonus: For the 2020 payment year, CMS proposes a complex patient bonus based on the individual clinician's HCC score (or the group's weighted average HCC score). The bonus would be up to three points, ranging from 1.16 points in the first quartile to 2.49 points for individual reporters submitting six or more measures.² **HFMA strongly supports the bonus, but is concerned that it is too low to compensate clinicians who care for complex populations. Based on CMS's discussion of its analysis in the proposed rule, HFMA's members believe the bonus should be five points, given the challenges facing providers who care for clinically complex populations.**

² Groups would range from 1.26 points in the first quartile to 2.23 points in the fourth quartile.

“Dual-Eligibles” Based Complexity Bonus: In the rule, CMS proposes an alternative complexity adjustment of up to five points based on the percentage of a clinician’s Medicare patients who are eligible for both Medicare and Medicaid. There is a significant body of research indicating the “dual” status is a strong proxy for underlying socioeconomic issues^{3,4,5} that have a significant negative impact

on both cost and outcome measures. During discussions of the proposed rule, HFMA’s members pointed out that it is possible for a physician to serve a population that is clinically complex but not socioeconomically challenged, and vice versa. Therefore, HFMA strongly recommends that CMS, in addition to finalizing the HCC bonus with the modifications described above, implement a separate bonus based on the percentage of dual-eligible patients in a clinician’s panel.

Definition of a Group Practice - Split Reporting TINs: In the 2017 QPP final rule, CMS defined a group as a single TIN with two or more eligible clinicians (including at least one MIPS-eligible clinician) as identified by their National Provider Identifiers (NPIs), who have assigned their Medicare billing rights to the TIN. CMS also defined an APM Entity group as a group of eligible clinicians participating in an APM Entity, as identified by a combination of the APM identifier, APM Entity identifier, TIN, and NPI for each participating eligible clinician.

CMS clarifies it considers a group to be either an entire TIN or the portion of a TIN that (1) is participating in MIPS according to the generally applicable scoring criteria while the remaining portion of the TIN is participating in a MIPS APM or an Advanced APM, according to the APM scoring standard; and (2) chooses to participate in MIPS at the group level. Groups without at least one APM participant are not permitted to “split” TINs.

HFMA’s members appreciate this clarification. However, we ask CMS to reconsider its stance on “splitting” TINs. Our members in large, multi-specialty group practices report that this disadvantages their practices as they are consigned to selecting reporting measures that do not accurately reflect the performance of all physicians in the group. **HFMA’s members request the ability to split TINs so that different specialties within a large group practice have the ability to report metrics that are meaningful for the physicians in those specialties.** We believe this will encourage performance improvement efforts by giving a wider range of physicians the opportunity to earn performance payments based on their individual efforts.

Quality Improvement Scoring: CMS proposes to expand the quality category performance assessment to include improvement scoring for performance year 2018 (payment year 2020). If finalized, the rule would add up to 10 percentage points to the quality performance score. **HFMA strongly supports the addition of an improvement scoring component.** However, we are concerned that the relatively low cap will not reward practices that make substantial improvements in quality measures. For clinicians/practices with quality scores that start at a relatively low point compared to peers, this could blunt the incentive to pursue performance improvement efforts due to the high costs associated with

³HHS Office of the Assistant Secretary for Planning and Evaluation. “Report to Congress: Social Risk Factors and Performance under Medicare’s Value-Based Purchasing Programs.” Dec. 21. 2016. <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs>

⁴ Calvillo-King L, Arnold D, Eubank KJ, Lo M, Yunyongying P, Stieglitz H, et al. “Impact of social factors on risk of readmission or mortality in pneumonia and heart failure: systematic review.” *J Gen Intern Med.* 2012;**28**(2):269–82.

⁵ Arbaje AI, L Wolff J, Yu Q, Powe NR, Anderson GF, Boulton C. “Postdischarge environmental and socioeconomic factors and the likelihood of early hospital readmission among community-dwelling Medicare beneficiaries.” *Gerontologist.* 2008;**48**(4):495–504.

reporting measures and undertaking practice improvement efforts compared to the relatively low likelihood of receiving performance payments (particularly as the performance threshold increases in future years). For practices that have strong performance against quality measures that are close to “topped out,” the low return on improving performance compared to prior years could act as a disincentive to report quality measures that they have not historically performed well against. This in effect could isolate performance quality improvement activities in a narrow range of quality measures that are broadly reported.

HFMA’s members believe that CMS needs to increase the number of points available through “improvement scoring” to reward clinicians who show exceptional improvements. HFMA’s members support moving to an “attainment” or “improvement” scoring model like that found in the hospital

value-based purchasing program (HVBP). As CMS notes, it is more complex than the method currently proposed. However, it was purposefully implemented in the IPPS so as not to penalize underperforming hospitals. As discussed above, we believe clinicians subject to MIPS adjustments may be exposed to a similar phenomenon. And, unlike in HVBP where the slate of metrics is fixed, this model provides some incentive to submit measures on which clinicians have not historically performed well.

AAPM Incentive

Availability of AAPM Models: HFMA strongly encourages the CMS to work with the Center for Medicare & Medicaid Innovation (CMMI) to expand the number of AAPMs that will allow clinicians to qualify for the AAPM incentive payment. Specific suggestions for increasing the number of AAPMs are discussed below.

Medical Home Exclusion from the AAPM Incentive Payment for Large Practices: HFMA strongly supports CMS’s decision to allow round one Comprehensive Primary Care Plus model participants in practices larger than 50 clinicians to continue to qualify for the AAPM incentive payment in payment year 2020 and subsequent years. However, as discussed in our prior MACRA-related comment letter, we strongly encourage CMS to remove the artificial limitation prohibiting large practices participating in AAPMs that would otherwise qualify under the Medical Home Financial standard from receiving the AAPM incentive payment.

HFMA continues to believe that CMS is adding words to the MACRA statute that do not exist. The section of the law that defines an Eligible Alternative Payment Entity states the following:

(D) ELIGIBLE ALTERNATIVE PAYMENT ENTITY.—The term ‘eligible alternative payment entity’ means, with respect to a year, an entity that—

(i) participates in an alternative payment model that—

(I) requires participants in such model to use certified EHR technology (as defined in subsection (o)(4)); and

(II) provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i); and

*(ii)(I) bears financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount; or
(II) is a medical home expanded under section 1115A(c).*

Nothing in the excerpted section above (or other sections of the law that pertain to how a provider or a practice may qualify for the AAPM incentive payment) explicitly or implicitly excludes a physician group participating in a medical home model that meets the financial risk standards defined by CMS from qualifying for the AAPM Incentive payment if the number of eligible clinicians in the practice or parent organization exceeds a maximum size. **Given this, HFMA strongly recommends that CMS remove the medical home maximum organization size requirement in the Final Rule.**

HFMA believes that Congress included the medical home pathway out of recognition that some practices, regardless of size, will be unable to bear downside risk during the period that the AAPM incentive payments are available. First, the CMS and CMMI models that qualify for the AAPM incentive payment are relatively new and their business models remain relatively unproven. The methodology used to determine their benchmarks is still likely subject to significant revisions that could negatively impact performance. Many executives are unwilling to expose their organizations to this policy risk and the related potential for arbitrary losses inherent in these models as CMS refines the benchmarking methodology.

Further, HFMA's members believe that organization size speaks to a necessary but not sufficient component to bearing risk. While practice size, as CMS suggested in the 2016 Proposed Rule, may suggest an organization has the financial wherewithal to bear some degree of risk, it does not correspond to the organization's ability to actually manage that risk. HFMA, through its Value Project research, has defined the core capabilities⁶ our members believe are necessary to manage risk. Given the considerable investments in personnel and infrastructure required to develop the capabilities, HFMA's members believe that Congress intended the medical home pathway to be a mechanism to help practices fund investments in these capabilities so they will be prepared for payment models that require significant two-sided risk.

Finally, HFMA's members believe that CMS's choice of 51 or more eligible clinicians as the maximum sufficient size of an organization required to successfully bear risk is arbitrary. We are unaware of any peer-reviewed studies or data that suggest this breakpoint.

Increase the Number of Specialty-Specific AAPMs: HFMA remains deeply concerned by the dearth of specialist payment models that qualify as AAPMs. We encourage the administration to finalize the next iteration of the Bundled Payments for Care Improvement (BPCI) program as soon as possible. **Given the delay in releasing it, we strongly support CMS's proposal to allow clinicians to qualify based on the percentage of patients provided services during the time period in which the AAPM is "actively tested."**

⁶ Healthcare Financial Management Association. 2015. *The Value Project Sourcebook*. www.hfma.org/valueproject/valuesourcebook/

We also strongly encourage CMMI to expedite consideration and development of models recommended by the Physician Technical Advisory Committee (PTAC). Additionally, assuming it would not slow evaluation of potential Medicare payment models, HFMA would cautiously support efforts by CMS to expand the PTAC’s scope to include models where Medicaid and the Children’s Health Insurance Program (CHIP) might be a payer. We would specifically encourage the development of models focused on dual-eligible beneficiaries given that they are typically higher cost than average. We believe models that consolidate the healthcare funding streams for dually eligible patients have the potential to generate significant cost savings and improve overall patient outcomes by eliminating gaps in covered services.

Create a Demonstration Testing the Ability of Medicare Advantage Risk Contracts to Control Cost: HFMA encourages CMS to use its demonstration authority to create a voluntary Medicare Advantage (MA) APM that would qualify participating clinicians for the 5 percent MACRA bonus and exempt those clinicians from MIPS. Specifically, CMS has the legal authority to use Section 1115A of the Social Security Act to test new models with the potential to lower costs and maintain or improve the quality of care offered to patients. CMS should use this legal authority to design a demonstration project to compare

the cost and quality of care delivered in risk contracts between MA plans and physician organizations to the cost and quality of care delivered in traditional Medicare.

This MA APM option would then become a “qualifying model” under the MACRA statute by virtue of being an Innovation Center demonstration. Furthermore, once within the Innovation Center, CMS can use waiver authority to modify the existing Medicare Part B revenue test to include MA revenue, creating a modified revenue threshold that includes Medicare risk revenue from Part B and MA risk revenue. In addition, or in the alternative, CMS could use the patient count threshold without a waiver, as the language for that category is broader and permits the inclusion of MA patients as currently written. Under either method, HFMA’s members stress that either method of combining Part B and MA risk revenue should only apply to clinicians who are voluntarily participating in the MA APM option. Below is a detailed description of the model we are suggesting. We note that this incorporates much of what CMS itself has proposed for the all-payer calculation that is required to begin in the 2019 payment year with some modifications. We urge CMS to adopt this demonstration project in 2018. Not only will that benefit clinicians by allowing them to participate in the AAPM track of MACRA, should they desire to do so, but it will give the agency crucial experience with a significant component of the AAPM all-payer option prior to the nationwide rollout of that option.

First, as CMS describes in the proposed rule, we would use the eligible clinician submission option to allow medical groups to submit MA risk contract information to CMS for consideration as an AAPM. Leveraging the existing administrative systems will bring efficiency and accuracy to the program.

The group practice would submit a summary of relevant contract terms⁷ of its contract with the MA plan to CMS for approval as an AAPM-qualifying model. The group practice would also submit a list of clinicians participating in the risk contract, including the TIN-NPI combination for each clinician. The group practice would attest to its MA revenue and MA patient count information. CMS will calculate the

⁷ See discussion of “All-Payer Option” Administrative Burden

traditional Medicare information for the practice, just as it currently does for traditional Medicare AAPM participants.

CMS will use the reported TIN-NPI combinations to identify the individual clinicians and tally the Part B revenue for participating clinicians for purposes of calculating the amount of the bonus CMS will pay. This step is identical to the process CMS uses for AAPMs under current regulation.

Note, unlike the CMS proposal for implementing the all-payer thresholds, we propose that CMS calculate the risk and patient count threshold performance at the group practice level, not at the individual clinician level. Once that risk level is achieved by the APM entity, CMS should use the traditional Medicare revenue information to pay the bonus to the participating clinicians' Medicare Part B billing TINs. This is consistent with current CMS practice in traditional Medicare.

We believe assessing risk at the individual clinician level is unworkable. The key reason is that risk contracts in MA tend to exist between the group (APM entity) and the plan and not between individual clinicians and the health plan. Instead, individual clinicians may contract for a sub-capitated payment, salary, or other form of compensation from the physician group. We believe a standard that requires individual clinicians to report all of their income from different sources and determine risk at

the individual level will be unworkable, burdensome, and will not necessarily give CMS the information it needs about the underlying contract between the MA plan and the group. Furthermore, the individual clinician assessment does not align to what is required in traditional Medicare, where, in general, risk is assessed at the group level. Creating a different standard in MA adds unnecessary complexity to the implementation of the QPP.

“All-Payer Option” Administrative Burden: The MACRA statute created an option for AAPMs to meet the revenue or patient count thresholds by adding their all-payer revenue (commercial, MA, and Medicaid) to their Medicare Part B risk threshold beginning in the 2021 payment year. The proposed rule provides additional details on how the all-payer threshold could be met.

HFMA supports CMS's proposal to have both a payer-initiated process and an APM entity or clinician-initiated process to become an AAPM. However, we are concerned about the level of supporting documentation CMS indicates it will collect. This includes copies of contracts and other underlying materials. **HFMA encourages CMS to limit its requests for information to that which supports the model's qualifications as an AAPM (quality, Certified EHR Technology, and risk). We do not think that full contract disclosure is necessary. As discussed in prior comment letters, our members are concerned that requiring additional, unnecessary documentation will serve as a barrier to participation.**

Further, CMS proposes that QP determinations under the all-payer combination option would be performed at the individual eligible clinician level only (not at the physician group or APM entity level). The proposed rule states there will be significant challenges in making these determinations at the group level. In order to determine whether the individual clinician is a QP under the all-payer combination option, CMS suggests that it would need all of the payment amount and patient count information attributable to the clinician through every other payment AAPM and for all payments or patients (except excluded payer types) made or attributed to the clinician in the performance period.

HFMA believes requiring individual clinicians to submit all of their payment information every year creates a significant administrative burden. Although the proposed rule allows groups to report on behalf of their individual clinicians, we still think that requiring this information on behalf of each clinician will serve as a disincentive to participate in the all-payer option. Additionally, as noted above, the contract between the plan and the group practice likely would not speak to the terms of individual clinician compensation. This would require an analysis of a clinician’s employment agreement with the medical group. HFMA’s members are concerned that the individual approach proposed might require a group to disclose every employment agreement with its contracted clinicians so that CMS could assess how much risk each clinician is bearing. This would add considerable, unnecessary administrative expense and significantly limit the number of practices that participate in the “all payer option.”

Finally, this requirement is inconsistent with what CMS has implemented for traditional Medicare, where risk is judged at the group level. Consistent standards should be used across the payer types to harmonize requirements and incentives, reducing complexity for clinicians. **Therefore, HFMA strongly recommends CMS assess risk threshold requirements at the APM entity level for the all-payer option just as it does for the Medicare option.**

Opportunities for Administrative Simplification

Necessary Changes to Fraud and Abuse Laws to Support Provider Alignment: HFMA is deeply disappointed that the Proposed Rule does not mention any efforts on CMS’s part to work with the Office of Inspector General (OIG) to create the necessary safe harbors from the existing antiquated fraud and abuse regulatory regime.

By tying a portion of most physicians’ Medicare payments to performance on specified metrics and encouraging physician participation in APMs, MACRA marks another step in the healthcare field’s movement to a value-based paradigm from a volume-based approach. To achieve the efficiencies and care improvement goals of the new payment models, hospitals, physicians, and other healthcare providers must break out of the silos of the past and work as teams. Of increasing importance is the ability to align performance objectives and financial incentives among providers across the care continuum.

To do that, a legal safe zone for those efforts is needed that cuts across the fraud and abuse laws—specifically, the physician self-referral (Stark) law, anti-kickback statute, and certain civil monetary penalties (CMPs). In our view, these laws are not suited to the new models. The statutes and their complex regulatory framework are designed to keep hospitals and physicians apart—the antithesis of the new models.

HFMA believes that a single, broad exception that cuts across the Stark law, the anti-kickback statute, and relevant CMPs for financial relationships designed to foster collaboration in the delivery of health care and to incentivize and reward efficiencies and improvements in care is necessary. We recommend that the exception be created under the anti-kickback statute and arrangements protected under the exception be deemed compliant with the Stark law and relevant CMPs. HFMA asks that CMS work with the OIG where it sees opportunity within the existing statute to create this exemption, and with Congress where statutory adjustments are necessary to update the existing

fraud and abuse framework to allow providers the full range of actions necessary to respond to the economic incentives embedded in the MACRA legislation. We are concerned that failure to do so will negatively impact smaller practices. It will also increase employment of independent and small group practices by hospitals and large multispecialty practices that would otherwise want to remain independent.

Improving Quality Measures and Creating a Long-Term Vision for Quality Measurement: HFMA members continue to report that while payers are attempting to measure quality against common clinical conditions, each payer uses a slightly different measure. Reporting disparate measures for similar clinical conditions for multiple payers contributes to staff burnout and unnecessarily increases administrative expense without leading to a commensurate improvement in patient outcomes. A recent study of four physician specialties found that the average practice spends more than \$40,000 per year per physician reporting quality measures.⁸ This figure amounts to an estimated \$15.4 billion for these four specialties alone and represents a tremendous waste of resources that could otherwise be spent on patient care delivery. In light of this unnecessary resource use, we continue to encourage CMS to **use the recommendations of the National Academy of Medicine’s 2015 *Vital Signs* report to identify the**

highest-priority measures for development and implementation in the MIPS. To ensure that all parts of the healthcare system—hospitals, physicians, the federal government, private payers, and others—are working in concert to address priority issues, the *Vital Signs* report recommends 15 “Core Measure” areas, with 39 associated priority measures. These areas represent the current best opportunities to drive better health and better care based on a comprehensive review of available literature.

Finally, in addition to better focusing measures on the core areas identified in the *Vital Signs* report, our members request that CMS make its long-term quality measurement strategy public and broadly publicize its availability. While CMS has stated its intention to move to more outcomes measures over time (which HFMA fully supports), our members need to better understand the path CMS intends to take to get there. This will allow providers to make efficient investments in the necessary infrastructure to support quality reporting and the analytical tools that drive quality improvement.

Improving Cost Measurement: HFMA appreciates CMS’s concerns about physicians’ understanding of cost measures in the proposed rule. Our members continue to report that the physicians they employ find the existing suite of cost measures unnecessarily complex and difficult to understand.

HFMA fully supports CMS’s proposal to remove the ten episode-based measures for the 2018 performance period. **While we generally support episode-based cost measures as a bridge step to outcome-based payment models, HFMA’s members strongly encourage CMS to pilot the new episode measures with a broad cross-section of physicians before it attempts to integrate them into the cost category in the MIPS program.**

Further, our members report that physicians continue to struggle in understanding the Medicare Spend per Beneficiary (MSPB) metric. Common criticisms that arise include the difficulty of understanding why a specific patient is attributed to a physician and understanding what is included in the measure and what is excluded. This criticism is more prevalent from specialists who work in tertiary/quaternary

⁸ <http://content.healthaffairs.org/content/35/3/401.abstract>

settings. Beyond providing additional education on the MSPB and other cost measures as CMS proposes, **HFMA encourages CMS to work with stakeholders to develop new cost measures that are less complex.**

Provide Increased Physician Practice Support: HFMA's members believe that CMS needs to provide more tactical support to practices. We continue to hear from members that at times, particularly after new regulations are released, they struggle to get relatively basic questions (e.g., "In the context of a given program, what is the definition of a group?" "How does program A interact with program B?" "Will reporting certain data satisfy a given measure?")

While HFMA's members commend CMS's efforts to communicate program changes via fact sheets and webinars, they strongly recommend that CMS make virtual "office hours" available to practices of all sizes to help them understand: 1) new programs, 2) the metrics they report and how to use Quality and Resource Use Reports (QRUR), and 3) how to impact metric performance.

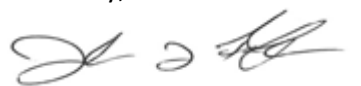
Improve the Reliability of the Group Practice Reporting Option (GPRO) Reporting Mechanism: HFMA's members continue to experience challenges reporting quality data through the GPRO website. Common issues reported are frequent crashes and partial data loads. Often it can take a week or more to connect with technical support to resolve these issues. Inputting data (and in many cases re-inputting data into

the GPRO website) is labor intensive and typically requires clinical staff for a week or more, which pulls them away from providing patient care, adding administrative cost without improving quality. **HFMA's members request that CMS work with stakeholders to improve the GPRO website to streamline data inputting and improve its reliability. We further encourage CMS to improve both the quality of the technical support available to physician practices and its accessibility.**

HFMA looks forward to any opportunity to provide assistance or comments to support CMS's efforts to refine and improve the QPP Proposed Rule. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS, and advisory groups.

We are at your service to help CMS gain a balanced perspective on this complex issue. If you have additional questions, you may reach me or Richard Gundling, Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, HFMA, CPA
President and Chief Executive Officer
Healthcare Financial Management Association

About HFMA

HFMA is the nation's leading membership organization for more than 38,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery



systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information, and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards.