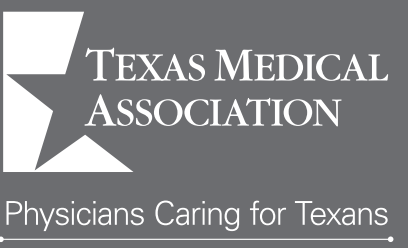
TEXAS MEDICAL ASSOCIATION

MACRA

Position Statement

FINAL: JULY 2016



The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was a critically important piece of Medicare legislation because it eliminated the congressional budgetary fiction known as the Sustainable Growth Rate (SGR) formula. The priority and urgency of the annual efforts to override the SGR fee cuts allowed other Medicare problems to develop and fester, with insufficient scrutiny of their efficiency or effectiveness.

In an attempt to address some of these other problems, MACRA consolidated and revised Medicare's physician penalty and incentive programs, hoping to simplify and improve them. Unfortunately, as we review the draft implementing rules, it appears that the net result will be neither simplified nor improved.

The Texas Medical Association is recommending extensive alterations to the Centers for Medicare & Medicaid Services' (CMS') draft implementing rules for the new Merit-Based Incentive Payment System (MIPS). Where the language of the law limits regulatory latitude, we recommend changes to the enabling legislation to ensure Congress' desired outcome of managing the cost and improving the quality of medical services.

Congressional Intent

MACRA has already accomplished two of its intended goals. It reauthorized the Children's Health Insurance Program (CHIP) for two years, and it removed the constant threat of SGR-driven Medicare payment cuts. The SGR's faulty assumptions would have forced annual fee cuts for physicians for every one of the past 15 years. The apparent folly of that policy drove Congress to override each of those cuts since 2002, often in desperate, last-minute or retroactive circumstances. The associated financial threats and uncertainty about business viability created continuously hazardous conditions for physicians' practice management and business operations planning. Physicians nationwide cheered the repeal of the SGR.

MACRA also promised to simplify the ever-tightening thicket of federal regulations that strangle physicians' practices. The draft regulations that CMS published May 9 fall far short of that promise. If implemented as written, they would dump additional bureaucratic work on physicians and their practices, and would continue to impose onerous federal controls on physicians and their practices — with no data to show that they would improve the quality of or access-to-care for patients. The system devised by CMS is far more costly, complex, and confusing than the costly, complex, and confusing programs it is replacing. Compliance would be especially difficult for small practices who may end up with Medicare payment penalties even if they spend the time and money to jump through all the new regulatory hoops. The budget-neutral system of bonuses and penalties pits physician practices against each other, so that there will be annually anointed winners and losers regardless of how well all practices "perform" on these new quality standards.

MACRA's Pain Points

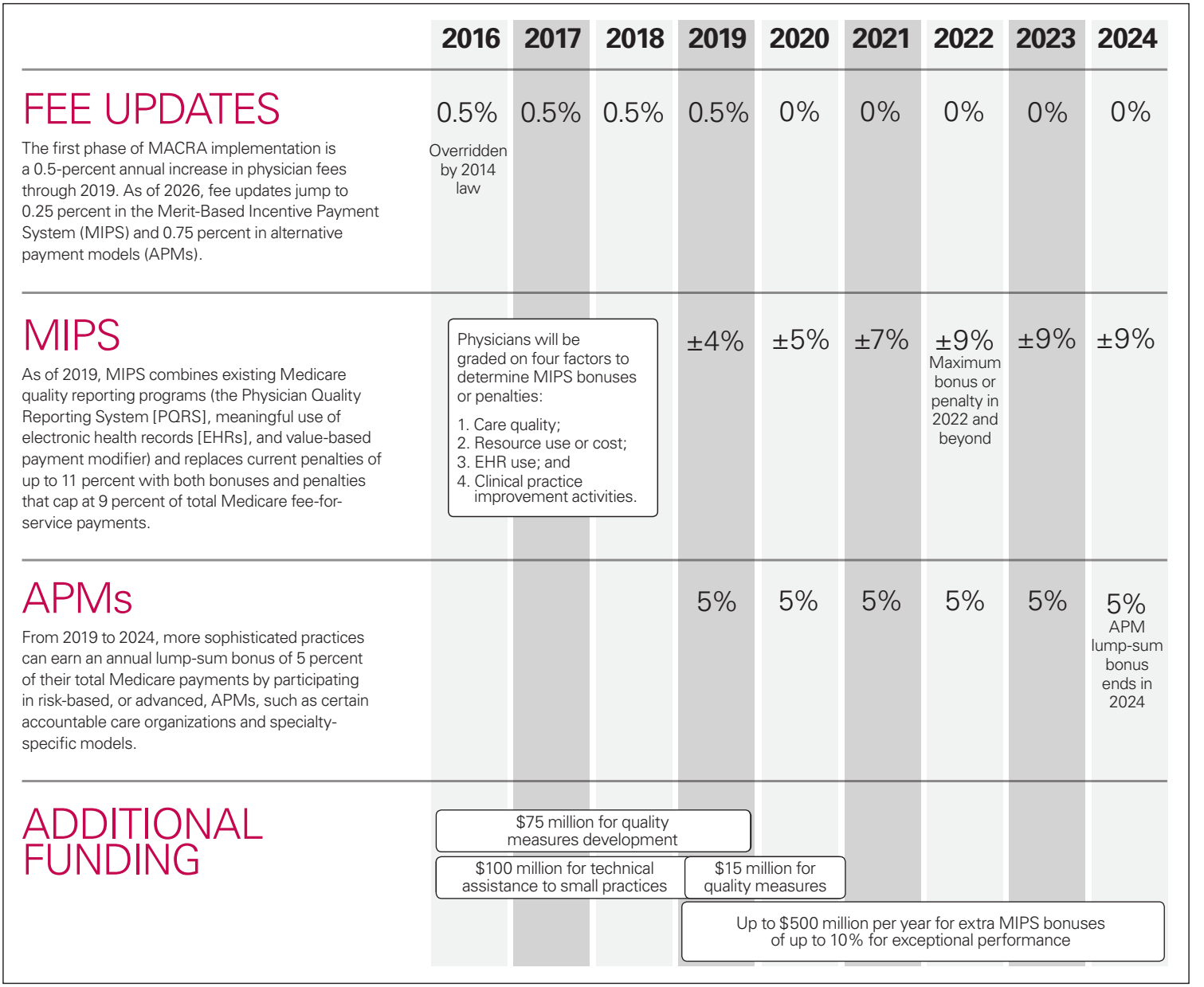
When MACRA legislation was enacted, TMA had no idea CMS would propose to continue flawed concepts from the current quality programs along with plans to diminish a physician's worth down to a complex point system. More disappointing is to learn that CMS proposes (see Table 64 on page 12, published on page 28375 of the proposed rule) to design a program that is stacked against solo physicians and small group practices in its first year of implementation.

CMS and proponents of the agency's proposed plan say it will streamline the current quality reporting systems and simplify the transition to value-based care. CMS' acting director says "we have to get the hearts and minds of physicians back," and he claims MACRA will "put physicians back in control." Our analysis of the proposed regulations reveals something much to the contrary.

We found:

- Costly Reporting and Compliance: The compliance, documentation, and reporting requirements related to the new combined incentive programs are inordinately costly for many physicians. CMS own figures show that the new programs will add an additional compliance cost of $128 million above the pre-existing cost of the programs it is replacing.
- Disjointed Timelines and Perverse Incentives: CMS has failed to properly engage physicians and guide them to successful participation since the current program was first implemented in 2007. The replacement does little to reverse the problems in the current systems, and in fact immediately increases the requirements for "success." The first year of implementation is not the time to raise the bar and increase the degree of difficulty in meeting quality reporting requirements.
- Metrics Outside of Physician Control: Vendors and patients, not physicians, have control over meeting MACRA's standards and requirements. Physicians should not be penalized for the failures of their electronic health record (EHR) vendors or for the demographic or socioeconomic status of their patients.

MACRA Timeline



Sources: Texas Medicine reporting; American Medical Association; and "Medicare's New Physician Payment System," Health Affairs and Robert Wood Johnson Foundation Health Policy Brief, April 21, 2016, tma.tips/HealthAffairsMACRA

- Two Years Too Late: CMS plans to use two-year-old data to determine whether physicians receive a bonus or penalty. Data from 2017 will be used in 2019, 2018 data in 2020, and so on. At no point in the process will physicians be provided feedback on their current performance data or insights within the current performance year on how to improve their status, and no objective standard will exist for physicians to target. Physicians should be given real-time and correct information on their practices.
- Arbitrary Incentives to Create Massive Changes in Physician Practice Type: The need for sophisticated support systems, the inflexibility of the measurement standards, and the lack of realistic incentives to change all create pressures for physicians to abandon small practices to join large ones — or to sell out to hospitals. In fact, CMS' published data shows that payment penalties could decimate small practices, still the majority in Texas.
- Cost Without Benefit to Medicare: There is no evidence that the incentives in the draft MACRA regulations are likely to be effective in improving care quality or increasing efficiency. Requirements should include only activities proven to actually enhance care quality, or to reduce cost with no adverse impact on quality, access, or productivity.

Proposed Treatment

On behalf of our nearly 50,000 physician and medical student members, the Texas Medical Association urges members of Congress and the leadership of CMS to chart a different course of action. We call on them to take the time necessary to ensure that this new law supports and enhances the physicians who provide the medical care to our nation's 54 million Medicare beneficiaries. We urgently request that CMS stop moving down a path that threatens to plow under tens of thousands of physician practices and needlessly create an access crisis for patients covered by Medicare.

Our detailed recommendations follow, but in general we are asking for time, fairness, simplicity, and flexibility. More precisely:

1. Exempt physicians who have no possibility of earning more than it costs them to report data and do not force physicians into unacceptably risky payment models.
2. Establish objective and timely measurement and reporting systems that are simpler and less costly than those currently required. The focus should be improving care for all Medicare patients, not creating yearly physician winners and losers with payment affected two years after care has been delivered.
3. Use quality metrics that capture those activities that are under the physician's control and have been shown to improve quality of care, enhance access-to-care, and/or reduce the cost of care. The focus should be on metrics that are most meaningful to a practice and its patients, not on what will result in the best "score."
4. Allow physicians who want to shift to value-based care enough time to make this transition in a way that actually benefits their patients and does not cause undue collateral damage to their practices.
5. Require EHR vendors to build and maintain products that meet federal specifications rather than forcing physicians to purchase and constantly upgrade expensive and often-balky systems.

Summary of Recommended Changes

Changes Requiring Congressional Action

- Remove all penalties and the requirement for budget neutrality. If Congress is confident these requirements will improve outcomes or reduce cost, it should fund them with federal spending, not by forcing small practices to pay.
- Remove all administrative requirements that are not supported by evidence of efficacy.
- Require CMS to set the threshold for the composite performance score at 15 percent or less for the first reporting year.
- Remove the composite performance score minimum requirement that forces the maximum penalties on physicians who meet only some of the costly reporting requirements.
- Require proper risk adjustment of all cost and quality measures to remove the known correlations to demographic variables that are outside of physician control. These include poverty; poor educational attainment; cultural, racial, ethnic, and religious affiliation; and a history of uninsured status.
- Remove the requirement that physicians must accept insurance-type, downside risk in order to earn incentives in alternative practice models.
- Remove the preferential treatment for physicians who use certain services provided by third party data submission vendors. Those vendors should compete for physician business on a level playing field.

Changes Needed in Rulemaking Within the Parameters of Current Law

Minimum Six-Month Deferment and Six-Month Performance Period in 2017

- Since the proposed rules won't be finalized until on or around Nov. 1, 2016, a six-month deferment is necessary to foster program readiness. The performance period should start July 1 and end Dec. 31. This timeframe will help with CMS' plans to offer guidance and assistance to physicians in practices of 15 or fewer eligible clinicians.

Low-Volume Threshold

- Set the low-volume threshold high enough to exempt physicians who have no possibility of a positive return on their investment in the cost of reporting. Since the ongoing cost of reporting, on the quality measures alone, is more than $10,000 per year per physician, and physicians who undertake the reporting efforts can, on average, expect to avoid penalties but not earn incentives, the low-volume threshold should be set in 2019 at $250,000 of Medicare revenue. At that amount, the avoided penalties at 4 percent would approximately equal $10,000. Below that amount there is no likely return that exceeds the costs of reporting. Below that amount, MIPS reporting should be optional, but physicians who attempt compliance should be exempt from penalties.
- Set volume minimums on all measures high enough to avoid the statistical volatility of small numbers.
- Preserve physician choice of payment model. No physician should be forced or coerced into accepting a payment model that is unacceptably risky for small practices, as small practices are likely to have a small and unrepresentative patient mix.

Alternative Payment Models (APMs)

- Include existing, successful APM program participants in the definition of Advanced APMs eligible for MACRA's financial incentives.

Real-Time Information

- Make feedback reports available during current reporting periods so that errors and omissions can be corrected in a timely fashion. Reports should be easy to access and understand, and should include a process to request and implement revisions when data are incorrect.

Focus on Areas Where Physicians Have Control

- Revise all quality and advancing care information (meaningful use) measures to exclude the effects of patient care preferences or choices, and patient inability or unwillingness to adhere to medical orders or advice.
- Remove all measures that have no proven efficacy.

- Base no financial incentives of any kind on measures that are not properly risk-adjusted.

Performance Threshold

- CMS has complete discretion to establish the performance threshold, which is the composite performance score that a physician must earn to avoid penalties. Furthermore, since the enabling legislation requires maximum penalties for scores below a quarter of the threshold, the threshold level controls how many physician will receive no credit for partial reporting. Setting the benchmark higher results in a larger shift of Medicare dollars from small physician practices to fund larger payments to hospitals and large health care systems. To minimize the potential negative impact of this untested methodology, the first-year performance threshold must be set very low. A performance threshold set at 15 percent would be optimal to reduce the negative impact on small practices, ensuring that physicians who were able only to report clinical performance improvement activities would gain full credit and avoid penalties, though they would not earn incentives.
- Revise all quality scoring so that half of the available quality credit is granted to any practice that reports the required data. Although reporting efforts may be unsuccessful, as we have seen in the Physician Quality Reporting System (PQRS) program, granting credit to reporting offers at least some likelihood of reward for physicians who undertake those costly efforts. Since performance outcomes and scores are highly unpredictable for small practices, this change is necessary to create some incentive to report.

Simplify the Quality Performance Point System

- The focus should be on quality measures that are most meaningful to a practice, not on what will result in the most points. The proposed methodology and point system provide bonus points for extra measures or reporting mechanisms and fewer points for other measures. This will create incentives for physicians to select measures that will result in the most points, not what is most meaningful to their practice and patients. Additionally, some specialties have very few measure options and will not have the option to work toward bonus points, which is blatantly unfair.
- Keep it simple. For the first performance period in 2017, physicians should report at least six measures *of choice* that are meaningful to their practice and patients. If fewer than six measures apply for the specialty, then only applicable measures should be required.

Eliminate Requirement for All Payer Data

- Under MIPS, CMS is proposing to require all payer data for the qualified registry, qualified clinical data registry (QCDR), and EHR reporting mechanisms, but only Medicare Part B data for the claims, web interface, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey reporting mechanisms. Medicare populations are very different from those covered by other payers. Having some practices submitting data that represent all payers and others providing Medicare only, coupled with the fact that quality benchmarks are based solely on Medicare data, will result in an inequitable assessment of quality performance. Additionally, this requirement will significantly increase the volume of data needed per measure and make it more difficult to meet the threshold requirements, which will result in failed reporting.

Reduce Reporting Thresholds

- Reduce the quality reporting thresholds from the proposed 80-90 percent of patients back to the current 50 percent per measure. Failure to meet the 50-percent threshold under PQRS is one of the main reasons physicians currently fail quality reporting. Under MIPS, any physician who fails to meet the threshold for any reason will get a zero score per measure and thus receive lower scores for the quality performance category. The first year of MIPS implementation is not the time to raise the bar and increase the degree of difficulty of meeting quality reporting requirements.

Create a "Hold Harmless" Policy

- Since CMS is designing the MIPS program to make physicians heavily dependent on third party data submission vendors for their quality reporting, create a "hold harmless" policy so that eligible clinicians who are adversely affected by vendors' data submission errors do not receive a penalty.

Hold EHR Vendors Accountable

- Eliminate surveillance of physician use of electronic health records. Focus instead on EHR vendor requirements and ensure the development of good design standards.

- Remove the requirement that physicians attest that they did not "knowingly and willingly take action ... to limit or restrict the compatibility or interoperability" of their EHR.

Findings and Recommended Changes

Costly Reporting and Compliance

We are very concerned that the compliance, documentation, and reporting requirements related to the new combined incentive programs are inordinately costly for many physicians. The vast majority of Texas physicians are not eligible to participate in Alternative Payment Models (APMs). Therefore, the costly efforts that must be undertaken to avoid penalties and/or earn incentives in the MIPS include all of the costs to learn program requirements, relearn them after frequent program revisions, investigate reporting options and requirements, select compliance methods, revise standard practice processes and guidelines to incorporate new protocols, train all relevant staff, perform related tests or interventions, document performance or results, report what was documented, verify receipt or processing of reported data, and defend the data in audit. Additionally, if the past is any indication, physicians will incur additional costs to install, upgrade, or replace software, and to purchase or license new or custom software interfaces, electronic communication methods, or custom reports. Many of these costs are subject to economies of scale, so they become cost-effective only for larger physician groups. Additionally many of the certified electronic health record technologies (CEHRTs) are not fully developed for all specialties. TMA analysis finds that small practices frequently will face a lose/lose scenario in which they either incur more cost than they can expect to receive in financial rewards, or they absorb the crippling penalties and abandon any effort to comply with program requirements.

Return on Investment — Full Compliance

Example Assumptions: Interest rate = 0% • Medicare Revenue per Physician $250,000

	2016	2017	2018	2019	2020	2021	2022
Penalty/incentive amount				4%	5%	7%	9%
Activity							
EHR implementation Costs — First 90 Days	$32,409						
EHR Maintenance Costs		$17,100	$17,100	$17,100	$17,100	$17,100	$17,100
Quality Reporting- Physician and staff labor		$10,598	$10,598	$10,598	$10,598	$10,598	$10,598
ACI (MU) Reporting — labor cost unknown		?	?	?	?	?	?
CPIA Cost — unknown but probably small		?	?	?	?	?	?
Total Annual Cost	**$32,409**	**$27,698**	**$27,698**	**$27,698**	**$27,698**	**$27,698**	**$27,698**
Return if penalties are avoided and incentives are earned	$0	$0	$0	$20,000	$25,000	$35,000	$45,000
Annual Profit/Loss	-$32,409	-$27,698	-$27,698	-$7,698	-$2,698	$7,302	$17,302
Accumulated Profit/Loss	-$32,409	-$60,107	-$87,806	-$95,504	-$98,202	-$90,900	-$73,599

Result: Even though we are unable to estimate some costs, compliance costs still far exceed any return from incentives and avoided penalties. Physicians would accumulate large net losses through 2022.

Sources:
- Based on Casalino, Gans, et al. US Physician Practices Spend More Than $15.4 Billion Annually to Report Quality Measures, *Health Affairs* 35, No. 3 (2016); 401-406
- Fleming et al., The Financial and Nonfinancial Costs of Implementing Electronic Health Records In Primary Care Practices, *Health Affairs* 30,

Return on Investment — Considering Quality Reporting Cost Only

Example Assumptions: Interest rate = 0% • Medicare Revenue per Physician $250,000

	2016	2017	2018	2019	2020	2021	2022
Penalty/incentive amount				4%	5%	7%	9%
Quality Reporting- Physician and staff labor		$10,598	$10,598	$10,598	$10,598	$10,598	$10,598
Accumulated cost		$10,598	$21,197	$31,795	$42,393	$52,991	$63,590
Return if all penalties are avoided				$10,000	$12,500	$17,500	$22,500
Annual Profit/Loss	$0	-$10,598	-$10,598	-$598	$1,902	$6,902	$11,902
Accumulated Profit/Loss	$0	-$10,598	-$21,197	-$21,795	-$19,893	-$12,991	-$1,090

Result: Considering quality compliance costs only, and an average result of avoiding penalties but not earning incentives, physicians will not break even for 6 years.

Source: Based on Casalino, Gans, et al. US Physician Practices Spend More Than $15.4 Billion Annually to Report Quality Measures, *Health Affairs* 35, No. 3 (2016); 401-406

The hoped-for reduction in these administrative costs with MACRA implementation has not materialized — even the draft rule's impact analysis reports that the new programs will add additional compliance cost of $128 million above the pre-existing cost of the current PQRS, meaningful use, and value-based payment modifier programs.

Since the quality reporting requirements in MIPS are even more stringent than the requirements of the predecessor program, we can estimate the compliance cost based on practice experience. A recent published study[1] in *Health Affairs* estimated the ongoing labor cost of reporting quality data to payers at more than $50,000 per primary care physician per year. (We note this is a stark contrast to CMS' estimate of the burden, which ranges from $18 to $1,294 per reporting mechanism per eligible clinician per year as noted in Tables 48-51 of the proposed rule.) If we assume, very conservatively, that this cost distributes evenly across all payers, we can use primary care payer mix data from MGMA cost reports to estimate that the Medicare portion of this cost is approximately $10,600 per physician per year.

CMS proposed a "low-volume threshold" exemption that excludes physicians with 100 Medicare patients and $10,000 in Medicare allowed charges billed. This proposal exempts only 10 percent of small practices. TMA recommends setting the threshold high enough to exempt physicians who have no possibility of a positive return on their investment in the cost of reporting. In 2019, that level would be $250,000 of Medicare revenue. At that amount, the avoided penalties at 4 percent would approximately equal the $10,000 cost of reporting Medicare quality data for a primary care physician. Below that amount there is no likely return that exceeds the costs of reporting. Below that amount, MIPS reporting should be optional, but physicians who attempt compliance should be exempt from penalties.

This does not even take into account the cost of compliance with the Advancing Care Information (ACI — formerly meaningful use) requirements, which is somewhat more difficult to estimate. This requires, at a minimum, implementation of an EHR system estimated in one published study[2] to be $32,409 per physician, plus annual maintenance costs of $17,100. This leads to a minimum annual cost per physician of $27,700 plus the one-time implementation cost (as well as any lost productivity and ongoing staff costs for learning and relearning program rules, data collection, data entry, and reporting).

Texas physicians' experience with PQRS, meaningful use, and the value-based payment modifier program further substantiate our expectations regarding the cost-effectiveness of participating in MIPS. Despite our extensive education and technical assistance activities to help Texas physicians navigate the current programs, 40 percent (30,364 out of 78,529) of eligible professionals in Texas did not participate in PQRS in 2014. Many TMA physician members report they have determined that the annual time, effort, and costs required to participate in the current programs outweigh their return on investment, and they do not foresee participating in MIPS. Many report they would rather take the payment penalty than break away from patient care to learn about the quality reporting requirements, track annual program changes, and facilitate paperwork — all to satisfy onerous government regulations and program requirements, which from their standpoint have not resulted in improved quality and patient outcomes.

Primary Care Annual Reporting Burden

MACRA Burden Estimate vs.
Cost of Actual Time Spent Reporting Quality Measures

Government's MACRA Burden Estimate*	
Claim Submission	$1,294
QCDR Submission	646
EHR Submission	724
CMS Web Interface	18
CAHPS for MIPS	23
QCDR & qualified registry self nom.	84
Data Validation & Auditing	34
Advancing Care Information	182
CPIA	182
Partial Qualifying APM Participant	84
Range	**$18 to $1,294**

*Table 60 p. 28363 Proposed Rules

Quality Reporting Actual Costs Primary Care**	
Physicians	$22,049
Nurse Practioners & PAs	4,208
RNs	2,702
LPN & Med Assistants	9,119
Admins	8,872
IT Experts	785
Billing/Coding/Med Records Staff	2,733
	$50,468

**Lawerence P. Casalino, et al

1 Casalino, Gans, et al. US Physician Practices Spend More Than $15.4 Billion Annually to Report Quality Measures, *Health Affairs* 35, No. 3(2016); 401-406

2 Fleming et al., The Financial and Nonfinancial Costs of Implementing Electronic Health Records In Primary Care Practices, *Health Affairs* 30, No. 3(2011); 481-489

National Physician Quality Reporting System (PQRS) Trends 2007-14

Performance Year	Payment Adjustment Year	Incentive Payment (bonus, plus 0.5% bonus for MOC participation)	Payment Adjustment (penalty)	Eligible Professionals (EPs) (physicians and non-physicians)	EPs Who Participated	National Average Participation Rate	EPs Who Qualified For An Incentive Payment (bonus)	EPs Who Received A Payment Adjustment (penalty)
2007	2009	1.5%	-	688,329	103,710	15.1%	55,244	-
2008	2010	1.5%	-	964,196	153,839	16.0%	85,481	-
2009	2011	2.0%	-	1,006,833	210,559	20.9%	120,665	-
2010	2012	2.0%	-	1,042,595	269,076	25.8%	194,278	-
2011	2013	1.0-1.5%	-	1,101,773	320,422	29.1%	266,740	-
2012	2014	0.5-1.0%	-	1,201,362	435,878	36.3%	367,240	-
2013	2015	0.5-1.0%	-1.5%	1,253,595	642,114	51.2%	494,100	457,628
2014	2016	0.5-1.0%	-2.0%	1,322,529	822,810	62.2%	585,037	558,885
2015	2017	-	-2.0%	*Results Pending*	*Results Pending*	*Results Pending*	*Results Pending*	*Results Pending*
2016	2018	-	-2.0%	*In progress*	*In progress*	*In progress*	*In progress*	*In progress*

NOTE: This table presents historical data and trends in PQRS participation from 2007 to 2014. CMS did not report the number of EPs who participated in PQRS but received neither the bonus nor penalty. Results include all reporting mechanisms and options.

Source: CMS 2014 Reporting Experience, *Including Trends* (2007-2015)

Perverse Incentives

Many Texas physicians are making a good faith effort to comply with quality reporting requirements and are doing their part in joining the nation on its journey and transition to value-based care. Participation in PQRS in our state is 61.3 percent, which is on par with the national average rate of 62.2 percent. However, in 2014, less than half of all eligible professionals in the nation actually benefited from reporting data on quality measures to PQRS, and a significant number of physicians are being penalized (a 2-percent penalty per claim for the entire 2016 calendar year) either through nonparticipation or for failing to meet the quality reporting requirements. This demonstrates that the overall quality reporting process continues to be a challenge among many physicians. Furthermore, this is an indication that CMS has failed to properly engage physicians and guide them to successful participation since PQRS was first implemented in 2007.

Because physicians often cannot control the events upon which they are being scored, they also cannot predict that costly efforts to report the required MIPS data will result in any positive return on investment. Prior to MACRA, physicians could avoid PQRS penalties by successfully reporting data. But while the proposed MACRA rules continue to require reporting, that alone is not sufficient to gain credit toward avoiding penalties or earning incentives. Furthermore, historical evidence shows that attempts to report the relevant data may be unsuccessful. CMS data[3] shows that in 2014, approximately 30 percent of the eligible professionals who attempted to report PQRS data failed to earn the available incentives. Even worse, in September 2015, CMS provided faulty PQRS and Value-Based Payment Modifier (VM) feedback reports to physicians, then reissued revised reports in late 2015 within a week of the informal review deadline. That resulted in mass confusion and missed opportunities for physicians to appeal their performance data and associated payment penalties. Additionally, a provision in MACRA that requires maximum penalties for practices that fall below one-quarter of an as-yet unspecified composite performance score (CPS) creates unacceptable risk for any practice that attempts to gain partial credit and limit compliance cost, for example by reporting only clinical practice improvement activities (CPIA) or ACI. So attempts to avoid penalties will require across the board compliance and reporting. Exacerbating the unpredictable return on investment, all costs will be incurred by the practice two years before it realizes any possible financial benefit, and even then the benefit is not guaranteed.

3 CMS 2014 Reporting Experience, *Including Trends* (2007-2015)

The focus of quality measures should be on those that are most meaningful to a practice and its patients — not on what will result in the best MIPS "score." As designed, the proposed methodology and point system provide bonus points for extra measures or reporting mechanisms and fewer points for other measures. This will create incentives for physicians to select measures that will result in the most points, not what is most meaningful to their practice and patients. Some specialties have very few measures available, and will not have the option to work toward bonus points. TMA recommends CMS simplify its point system and suggests that for the first performance period in 2017, physicians should report at least six measures *of choice* that are meaningful to their practice and patients. If fewer than six measures apply then only report on each measure that is applicable.

TMA recommends that quality scoring be revised so that half of the available quality credit is granted to any practice that reports the required data. Granting credit to reporting recognizes physicians who undertake the costly reporting efforts. Since performance outcomes and scores are highly unpredictable for small practices, this change is necessary to create some incentive to report.

The thresholds under MIPS also need to be reduced from the proposed 80-90 percent back to 50 percent per measure. Failure to meet the current 50-percent threshold under PQRS is one of the main reasons physicians fail quality reporting. Increasing the reporting threshold and requiring patient data from all payer data will result in undue administrative and cost burdens as eligible physicians and their staff will have to enter data on numerous patients per measure. Many PQRS participants have yet to master quality reporting under the 50-percent threshold, and increasing it will only result in more failed reporting. Under MIPS, any physician who fails to meet the threshold will receive a zero score per measure; that would result in lower scores for the quality performance category, which accounts for half of the total composite performance score. The first year of MIPS implementation is not the time to raise the bar and increase the degree of difficulty in meeting quality reporting requirements.

MIPS bonuses and penalties of up to 4 percent each begin in 2019 and increase to 5 percent in 2020, 7 percent in 2021, and 9 percent in 2022 and beyond. The bonuses are based on performance from two years earlier, meaning pay hikes and pay cuts in 2019 will reflect what a physician did in 2017. Physicians will have no opportunity to review their data or be given any real-time feedback on their performance. Worse still, there is no objective target for physicians to meet. Physicians will be judged against their colleagues across the nation using a bell-shaped curve. A high-performing physician one year could be penalized the next, then rewarded, and so on. Since much of the program focuses on filling out paperwork rather than providing good care, it appears the rewards will go to practices most capable of filling out the necessary forms. In order to achieve improvement, feedback reports should be timely, easy to access and understand, and should include a process to request and implement revisions when data are incorrect.

Weights by Performance Category

Performance Category	2019 MIPS Payment Year	2020 MIPS Payment Year	2021 MIPS Payment Year and Beyond
Quality	50%	45%	30%
Resource Use (Cost)	10%	15%	30%
Clinical Practice Improvement Activity	15%	15%	15%
Advancing Care Information	25%	25%	25%

NOTE: This table summarizes the weights CMS proposes for each performance category for the 2019, 2020, and 2021 MIPS payment years. The resulting weighted performance category scores would be summed to create a single composite performance score from 0-100. That score would then determine whether the physician receives a Medicare payment bonus, penalty, or neither.

Source: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; *Proposed Rule, 81 Fed. Reg. 28269* (May 9, 2016). *Federal Register: The Daily Journal of the United States.*

Disjointed Timelines

TMA strongly recommends the performance period for 2017 be reduced to six months. Since the proposed rules won't be finalized until on or around Nov. 1, 2016, a six-month deferment is necessary to foster program readiness. The performance period should start July 1 and end on Dec. 31. This timeframe will help with CMS' plans to offer guidance and assistance to MIPS-eligible clinicians in practices of 15 or fewer eligible clinicians.

We note that CMS plans to monitor practices for data validation, auditing, program integrity issues, and instances of noncompliance with MIPS requirements and will recoup overpayments in accordance with agency rules in the future. Two to three months is not enough time for program readiness for practices to ensure compliance and confidently undergo such audits.

Because the quality performance category is weighted at 50 percent in its first year of MIPS implementation, every point matters to reach the highest composite performance score possible. All physicians should have enough lead time to review and select their quality measures well before the start of the year, to align care plans and target or redesign clinical workflows to meet each quality measure, and then to ensure data fields in either paper charts or EHRs support and meet each measure's specifications and documentation requirements. These clinical actions and practice strategies are critical to reaching the highest quality performance score under the proposed new methodology.

The law requires CMS to encourage the use of QCDRs, which are allowed to report on an additional 30 measures not on the annual list of MIPS quality measures. All such measures for each QCDR will differ from each other. However, CMS states in the proposed rule that the list of measures available for reporting through QCDRs will not be available until spring 2017. Due to this delay, critical clinical actions will be missed for the first few months, which is not fair to eligible clinicians who choose to report through a QCDR and will only result in either failed reporting or poor quality performance.

A six-month deferment will help foster physician engagement and program readiness and will align with the agency's plans to offer guidance and assistance to practices of 15 or fewer MIPS-eligible clinicians.

Metrics Not Based on What the Physician Actually Controls

In MIPS scoring, physicians are penalized or rewarded based on variables that are not within their control. Physician performance scores are aggregated from four different performance categories: quality, resource use, CPIA, and ACI. Of these four areas, the new CPIA category may be the only one in which physicians wield substantial control over their own performance.

CMS has complete discretion to establish the performance threshold, the composite performance score that must be earned to avoid penalties. Furthermore, because the enabling legislation requires maximum penalties for scores below a quarter of the threshold, the threshold level controls how many physician will receive no credit for partial reporting. Setting the benchmark higher results in a larger shift of Medicare dollars from small physician practices to fund larger payments to hospitals and large health care systems. To minimize the potential negative impact of this untested methodology, CMS must set the first-year performance threshold very low. A performance threshold set at 15 percent would be optimal to reduce the negative impact on small practices, ensuring that physicians who were able only to report clinical performance improvement activities would gain full credit and avoid penalties, though they would not earn incentives.

Control over many cost-related standards and requirements may rest with vendors and patients, not physicians. Beneficiaries are constantly bombarded on television and through the mail to sign up for medical devices, drugs, and other supplies at little or no cost to them. Physicians, on the other hand, are held responsible for the cost of all this resource use and more. Medicare's benefit design grants patients nearly unrestricted access to covered benefits, physicians, and providers. This creates conditions where beneficiaries have significantly more control over many types of health care resources they use than any particular physician has. Furthermore, problems in categorization and attribution rules mean that physicians are held accountable for the costs of hospitalizations and other services that are completely unrelated to any of their own services, recommendations, or orders. Greater weight should be applied to CPIAs, not to ACI, quality, or cost, when

these other components are not available for scoring. Also, all measures that are not in physician control (example: total per capita cost) should be removed.

Similarly, physicians should not be penalized for the failures of their vendors. Since CMS is offering very few quality measures that are reportable through claims and has effectively designed MIPS to make physicians dependent on third party data submission vendors (qualified registry vendor, QCDR vendor, EHR vendor, health IT vendor, CMS-approved CAHPS survey vendor) for their quality reporting, physicians should not be penalized when vendors commit data submission errors. TMA recommends that CMS create a "hold harmless" policy so that eligible clinicians who are adversely affected by such vendor errors do not receive a payment penalty.

Many of the proxy measures used to assess quality are highly dependent on patient actions and choices. Patients choose whether to accept physician direction or advice, affecting treatment outcomes and many process measures. Many patient actions and decisions are more strongly correlated to demographic or socioeconomic variables, or to local access-to-care issues than they are to physician performance or actions. CMS should revise all quality and ACI measures to exclude the effects of patient care preferences or choices, as well as instances where the patient is unable or unwilling to adhere to medical orders or advice.

Depending on the specific circumstances, physician efforts to influence or modify patient decision making may be costly but have little or no possibility of attaining the desired results. CMS is now stating some future intention to pursue improved risk adjustment on some socioeconomic variables. No financial incentives of any kind should be based on measures that are not properly risk-adjusted.

Physicians Penalized for Serving the Less Fortunate

Patient demographic factors that relate to high cost, resource use, or poor outcomes, or that have adverse effects on other quality measures are not evenly distributed in the U.S. population. Studies have shown that poverty and lack of education are correlated with poor health outcomes, even when access to health care is universally available.[4] Patient demographic variables including gender and ethnicity have been shown to be related to medication compliance.[5] Racial, religious, or cultural variables affect patient preferences for care, including end-of-life choices about intensive care and resuscitation.[6] Patients with a lifetime history of poverty and poor access to medical care enter Medicare through age or disability, with pent-up demand that creates high cost and poor outcomes. MIPS resource use and quality scores, which are adversely affected by these variables, financially penalize the physicians who serve disproportionate numbers of patients from certain population subgroups. These include specific racial or cultural groups, and patients who have lived a lifetime of poverty without access to good medical care. We are confident that Congress did not intend to penalize physicians who care for large numbers of disadvantaged or minority patients, but that is the actual effect of the proposed MACRA rules. They create incentives for physicians not to serve certain patients and not to locate their practices in areas where poverty or other specific characteristics are prevalent.

We already see difficulties for small physician practices that care for patients in rural Texas, south Texas, and inter-city communities. They do not cherry-pick their patients but care for all patients in those communities. Small physician practices simply cannot accept more than nominal downside risk. Volume minimums should be set on all measures at levels high enough to avoid the statistical volatility of small numbers.

4 David A. Alter, Therese Stukel, Alice Chong and David Henry
Lesson From Canada's Universal Care: Socially Disadvantaged Patients Use More Health Services, Still Have Poorer Health
Health Affairs, 30, No.2 (2011):274-283

5 Ellis, J. J., Erickson, S. R., Stevenson, J. G., Bernstein, S. J., Stiles, R. A. and Fendrick, A. M. (2004), Suboptimal Statin Adherence and Discontinuation in Primary and Secondary Prevention Populations. *Journal of General Internal Medicine*, 19: 638–645.

6 Elizabeth D. McKinley, Joanne M. Garrett, Arthur T. Evans and Marion Danis
Differences in end-of-life decision making among black and white ambulatory cancer patients. *Journal of General Internal Medicine*, 1996, Nov;11(11): 651-6.

MIPS Proposed Rule Estimated Impact By Practice Size*

Practice Size	Eligible Clinicians	Percent Eligible Clinicians with Negative Adjustment	Eligible Clinicians with Negative Adjustment	Percent Eligible Clinicians with Positive Adjustment	Eligible Clinicians with Positive Adjustment	Eligible Clinicians with no Adjustment
Solo	102,788	87.0%	89,383	12.9%	13,302	103
2-9 eligible clinicians	123,695	69.9%	86,519	29.8%	36,887	289
10-24 eligible clinicians	81,207	59.4%	48,213	40.3%	32,737	257
25-99 eligible clinicians	147,976	44.9%	66,515	54.5%	80,588	873
100 or more eligible clinicians	305,676	18.3%	56,045	81.3%	248,626	1,005
Overall	761,342	45.5%	346,675	54.1%	412,140	2,527

NOTE: This table presents the estimated impact MIPS will have by practice size. As reflected in Table 64 of the MACRA proposed rule, MIPS will impose penalties (negative adjustments) on the majority of small physician practices. Because the law requires the program to be budget neutral, CMS will use those reductions in payment for small practices to fund incentive payments (positive adjustments) to large practices or hospital systems that have sufficient Medicare revenues to make the necessary reporting burden profitable.

*2014 data used to estimate 2017 performance.

Source: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; *Proposed Rule, 81 Fed. Reg. 28375* (May 9, 2016). *Federal Register: The Daily Journal of the United States.*

Arbitrary Incentives to Create Massive Changes in Physician Practice Type

The incentives created by MACRA will push a truly massive change in the entire structure of the ambulatory care marketplace. In Texas, more than 60 percent of patient care physicians are in very small practices of one to three physicians. MACRA is very likely to levy penalties on most of them, pushing some or all of them over time to retire, or join large groups or hospitals. This also likely will result in a shift away from practices in rural or small city settings and force these physicians into major urban areas where most large practices are currently located, making access more difficult for a large percentage of Medicare beneficiaries living in smaller communities. Such a huge disruption in the ambulatory care environment might be justified if there were evidence that the changes would result in better or more efficient care; but the evidence that exists does not support that notion. TMA is hopeful that CMS will recognize this dynamic and chart a different course to ensure these unwanted effects don't occur.

MIPS, as it is currently designed, includes insufficient incentives for most small practices to attempt the costly reporting processes inherent in the system design. As reflected in Table 64 on page 12, published on page 28375 of the proposed rule, MIPS will impose penalties on a majority of small physician practices. As a result of the budget neutrality requirements required in law, CMS will use those reductions in payment for small practices to fund incentive payments to large practices or hospital systems that have sufficient Medicare revenues to make the necessary reporting burden profitable. Although we are confident that this was not congressional intention, the net result is a large shift of Medicare funding from small practices to large groups or hospitals, with resultant pressures for physicians to abandon small practices. We question the wisdom of these incentives for multiple reasons. Small practices have generally operated with lower overhead cost, and adding administrative cost does not serve the broader purpose of making health care services less costly. Furthermore, there is evidence that patients can fare better and costs can be reduced with the personal attention in smaller physician practices. See, for example, a 2014 study[7] of Medicare data showing that patients in practices with one or two physicians had ambulatory care-sensitive admission rates that were 33 percent lower than those in larger practices of 10-19. Instead, TMA recommends segmenting ambulatory care into categories based upon practice size and then providing incentives that reward the best practices in each segment. These practices can then be modeled as high-performing with corresponding clinical data to support and encourage replication throughout the industry.

Physician choice of payment model also should be preserved. No physician should be forced or coerced into accepting a payment model that is unacceptably risky for small practices, as small practices are likely to have a small and unrepresentative patient mix.

7 Casalino et al, Small primary Care Physician Practices Have Low Rates of Preventable Hospital Admissions, *Health Affairs* 33. No 9 (2014)

Also, CMS should modify the low-volume threshold. The threshold should be set high enough to exempt physicians who have no possibility of attaining a positive return on their investment in the cost of reporting. The ongoing cost of reporting, just on the quality measures (see discussion above), is more than $10,000 per year per physician, and physicians who undertake the reporting efforts can, on average, expect to avoid penalties but not earn incentives. Therefore, the low-volume threshold should be set in 2019 at $250,000 of Medicare revenue. Below that amount, MIPS reporting should be optional, but physicians who attempt compliance should be exempt from penalties. At $250,000 in Medicare revenue, the avoided penalties at 4 percent would approximately equal $10,000. Below that threshold there is no likely return that exceeds the costs of reporting.

Alternative Payment Models

It is apparent that the long-term purpose of the proposed MACRA rule is for all physicians to participate in alternative payment models (APMs). This also will tend to push physicians into larger groups or health care systems. Insurance-type risk, when applied to small patient populations, is unacceptably volatile. A single poor outcome or high-cost case can cause the average cost to be well outside of acceptable results, potentially exposing the risk-bearing practice to financial losses. Physician practices do not have insurance-type reserves and cannot absorb financial losses other than those they already face due to charity care, bad debt, and underpayment or nonpayment by Medicare, Medicaid, and some other payers.

In response to Medicare's efforts to encourage the development of alternative payment programs, many independent Texas physicians have worked diligently over the past several years to build collaborations or groups with the appropriate relationships and infrastructure to successfully participate in various APM models. In many cases, these groups have undertaken substantial investment in developing working APMs, including investment in software and report customization, developing new communication methods, revising standard protocols and operational procedures, and retraining the medical team and all support staff. Some of these groups were early adopters and have been successfully participating in Medicare-approved programs for several years. Why should these successful APM programs be unable to qualify for the promised APM incentives? Physician practices should not see APM status as unattainable due to the high burden set by these regulations. Rather than creating barriers that prevent existing APM participants from qualifying as advanced APMs, we urge CMS to revise the proposed rule definitions to reward, rather than punish, the considerable efforts undertaken by currently qualifying APM participants.

Cost Without Evidence of Benefit to Medicare

We understand that the addition of administrative cost in the Medicare program is intended to create changes that ultimately would reduce total Medicare program cost. Evidence indicates, however, that the proposed methods actually will not yield the desired result. CMS and others have repeatedly tested various payment incentive programs that were designed to reduce costs by incentivizing physicians to perform differently. Historically, these efforts have not produced the intended results. There is no evidence that the particular incentives in the MIPS program are likely to be effective in improving care quality or increasing efficiency. There may hypothetically be payment initiatives that could produce the desired results, but there is no evidence that the current requirements and incentives will. Already, studies have shown that the similar Value-Based Purchasing program for hospitals has penalized hospitals that serve disadvantaged patients but has no measurable impact on outcomes[8]. That appears to be one of the reasons that CMS decided to provide positive incentives not only to high-performing hospitals, but also to hospitals that were low performing in their metrics. This is not the case for physicians; because of the budget neutrality provisions in MACRA, all of the costs of this unproven scheme are being born by practicing physicians. Advancing care information and clinical practice improvement requirements should include only activities proven to enhance care quality, or reduce cost with no adverse impact on quality, access, or productivity. All measures with no proven efficacy (example: hospital readmissions) should be eliminated.

8 Figueroa, at al., Association between the Value-Based Purchasing pay for performance program and patient mortality in US hospitals: observational study, *BMJ* 2016;353:i2214

We oppose the requirement for all payer data. Under MIPS, CMS is proposing to require all payer data for the qualified registry, QCDR, and EHR reporting mechanisms, but only Medicare Part B data for the claims, web interface, and CAHPS survey reporting mechanisms. Medicare populations are very different from those covered by other payers. Having some practices submitting data that represent all payers and others providing Medicare only, coupled with the fact that quality benchmarks are based solely on Medicare data, will result in an inequitable assessment of quality performance. Additionally, this requirement will significantly increase the volume of data needed per measure and make it more difficult to meet the threshold requirements, which will assuredly result in more practices that fail reporting.

To help meet the data completeness criteria per reporting mechanism, TMA recommends CMS improve and increase its efforts to adequately educate all physicians and group practices on how to avoid the numerous reporting pitfalls and how to meet all requirements successfully. Per the 2014 PQRS experience report, numerous challenges to quality reporting remain among many participants who are making a good faith effort to meet requirements. Since voluntary measure validation audits have been conducted over the past few years, CMS should make an increased effort to prevent the known root causes of data submission errors and make that information readily available so physicians may learn best practices.

Accurate and Appropriate Quality Metrics

All quality measures in the MIPS program must be adequately vetted with input from the medical profession and relevant stakeholders. All measures must be developed and maintained by appropriate professional organizations that periodically review and update them with evidence-based information in a process open to the medical profession. As evidence-based medicine is continually evolving, measures should be subject to regular review in accordance with current standards and whenever there is a major change in scientific evidence. TMA therefore opposes the use of any measure that has bypassed the standard vetting process by consensus-based entities and that has not been published in applicable, specialty-appropriate, peer-reviewed journals, or has not gone through the notice-and-comment rulemaking, or publication process in the *Federal Register*.

TMA opposes "appropriate use" measures in the MIPS quality performance category. The criteria used to evaluate physicians must be evidence-based, fair and accurate, and truly evaluate quality and efficient care, not just cost. CMS should not use measures based on so-called medical care guidelines (including, but not limited to, those published by actuarial firms) that are based on economic data. These types of measures interfere with the clinical decision making process and the patient-physician relationship.

TMA appreciates the effort set forth by CMS and the Core Measure Collaborative to reach a consensus on core quality measure sets. However, we are disappointed that more measures from the sets were not included. TMA believes more work can and should be done to simplify and align quality measures among all payers. To ease administrative burden among all physicians and groups, TMA recommends that the agency make measure alignment across all payers a top priority.

Surveillance of Physician Use of Electronic Health Records

CMS is proposing that physicians, as part of their demonstration of advancing care information, indicate they have cooperated with the surveillance of certified EHR technology. This surveillance would include responding to requests for information such as telephone inquiries and written surveys, and accommodating requests from the Office of the National Coordinator for Health Information Technology (ONC) or certifying bodies for access to the physician's EHR and the data stored in the EHR. CMS indicates these activities are not going to be unduly burdensome, but indeed they would be very burdensome and an unwelcome interruption to a busy physician and staff. Instead, TMA recommends that ONC leverage the work of the Strategic Health IT Advance Research Projects (SHARP) grant awarded to The University of Texas Health Science Center at Houston, whose initial purpose was exploring how to provide cognitive support to physicians using EHRs. The work of the researchers is significant as they made numerous recommendations for good EHR design to support physicians. EHR vendors should be required to adhere

2017 Proposed MIPS Quality Measure Sets Available to Various Specialties

Specialty or Subspecialty	Total Measures Per Set	Claims	EHR	Registry	QCDR (list of measures not available until spring 2017)
Allergy/Immunology/Rheumatology	15	2	3	14	Not available
Anesthesiology	7	1	0	7	Not available
Cardiology	15	2	5	15	Not available
Gastroenterology	7	3	1	7	Not available
Dermatology	6	1	0	6	Not available
Emergency Medicine	9	6	1	9	Not available
General Practice/Family Medicine	37	14	11	35	Not available
Internal Medicine	27	13	8	25	Not available
Obstetrics/Gynecology	14	5	2	12	Not available
Ophthalmology	15	6	6	14	Not available
Orthopedic Surgery	14	3	2	11	Not available
Otolaryngology	10	4	0	10	Not available
Pathology	8	8	0	8	Not available
Pediatrics	10	4	7	7	Not available
Physical Medicine	7	3	1	6	Not available
Plastic Surgery	3	2	0	3	Not available
Preventive Medicine	8	8	4	8	Not available
Neurology	18	3	1	17	Not available
Mental and Behavioral Health	12	2	2	10	Not available
Radiology, Diagnostic Radiology	14	7	0	14	Not available
Interventional Radiology	4	0	0	4	Not available
Radiation Oncology	4	1	2	4	Not available
Surgery, Vascular Surgery	6	0	0	6	Not available
General Surgery	8	3	0	8	Not available
Thoracic Surgery	9	2	0	9	Not available
Urology	7	2	1	7	Not available

NOTE: This table includes the number of MIPS measures available for the quality performance category per specialty (from Table E of the proposed rule, p. 28460). This table illustrates how many measures are reportable through Medicare Part B claims, EHR, Registry, or QCDR submission. The CMS proposed rule requires physicians to report at least six individual measures including one cross-cutting measure (if patient-facing) and at least one outcome measure, or if an outcome measure is not available, physicians must report on another high priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures). If fewer than six measures apply, then the physician must report on each measure that is applicable. Individual physicians submitting data using Medicare Part B claims must report on at least 80 percent of the Medicare Part B patients seen during the performance period to which the measure applies. Physicians submitting data on quality measures using QCDRs, qualified registries, or via EHR must report on at least 90 percent of all patients seen (all payer data) during the performance period to which the measure applies. Only one reporting mechanism may be used; since CMS requires a total of six measures, physicians in many specialties (marked in red) will not have the option to report through claims.

Source: *2016, Centers for Medicare & Medicaid Services, Proposed Rule, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Table E.*

to best practices of design, which is known to increase patient safety. CMS and ONC need to focus on EHR vendor requirements and good design standards rather than surveillance of end users. A well designed system will support various workflows and allow the end user to effectively choose best use of the product for the needs and goals set for best patient care and outcomes.

TMA also recommends that ONC and CMS glean feedback from users through other venues such as EHR user conferences or ONC-operated feedback portal.

Health Information Exchange Compatibility

TMA also recommends that CMS remove the requirement that physicians attest that they did not "knowingly and willingly take action ... to limit or restrict the compatibility or interoperability" of their EHR. While CMS indicated that some entities interfered with the exchange of health information, TMA contends that this would be a rare occurrence, and that the majority of physicians are eager for standards that facilitate the exchange of health information.

One of the biggest disappointments of the Health Information Technology for Economic and Clinical Health Act (HITECH) has been the hundreds of millions of taxpayer dollars spent to build the health information exchange infrastructure only to have the vendors extort physicians into paying exorbitant fees to map their data. In many instances, it is cost prohibitive for a physician to connect to the health information exchange. Is that physician then nonconforming because he or she "restricted" the compatibility or interoperability of the EHR?

The proposed rule also requires physicians to attest that they "implemented technologies, standards, policies, practices and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law and that the certified EHR technology was, at all relevant times connected in accordance with the applicable law." Physicians should not be required to be computer experts. This is akin to asking a pilot to certify that the plane's engine is built and installed according to set standards. Pilots are not required to understand the mechanics of an airplane, nor should they. Their skill set is flying the plane. Physicians should be trained to effectively use the EHR for patient care instead of being required to certify the EHR's construction.

Convoluted and Costly Data Submission Mechanisms

TMA is highly disappointed that many physicians will have to pay costly fees to report their quality data through third party data submission vendors. As evidenced by the very low number of claims measures reportable under MIPS (Table E, page 28460), it appears CMS intends to phase out the only non-fee based reporting mechanism available to small practices. Very few national specialty organizations offer qualified registries or QCDRs at no cost to their members. Participation in the majority of qualified registries and QCDR is priced at up to $800 per physician per year, and data integration services to obtain data from a practice's EHR or IT system require an additional expense starting at around $1,000. Although MACRA encourages the use of QCDRs, it does not call for eliminating claims reporting. To reduce administrative and cost burdens, TMA recommends CMS make a large number of measures reportable through the submission of claims data which can be provided at little or no cost to physician practices.

Furthermore, TMA opposes awarding bonus points in the quality scoring section for measures gathered and reported electronically via the QCDR, qualified registry, web interface, or CEHRT submission mechanisms over the claims reporting mechanism. These mechanisms require costly fees and the web interface reporting mechanism is applicable only to groups with 25 or more eligible clinicians. Awarding bonus points to practices that have the money and resources to facilitate these costly mechanisms over an individual physician who chooses to report via claims submission is unfair.

Glossary and Acronym Guide

MACRA: Medicare Access and CHIP Reauthorization Act of 2015
2015 law that repealed the sustainable growth rate formula for determining Medicare payments and created two new performance-based payment tracks: the Merit-Based Incentive Payment System and alternative payment models.

SGR: Sustainable Growth Rate
Former Medicare formula to calculate physician fee-for-service payment rates. Repealed by MACRA.

MIPS: Merit-Based Incentive Payment System
One of two payment tracks under MACRA. MIPS consolidates the Centers for Medicare & Medicaid Services' Physician Quality Reporting System, Value-Based Payment Modifier Program, and Electronic Health Records Incentive Programs into one single program starting in 2019.

APMs: Alternative Payment Models
One of two payment tracks under MACRA. Examples include accountable care organizations, patient-centered medical homes, bundled payment models, and other initiatives.

PQRS: Physician Quality Reporting System
Medicare program asking physicians to document and report on clinical quality measures. Scores feed into the Value-Based Payment Modifier Program.

VM: Value-Based Payment Modifier
Medicare calculation to adjust physician fee-for-service payments either up or down based on how they perform on quality and cost factors.

MU: Meaningful Use
Refers to meaningful use of electronic health records, which is the objective of CMS' Electronic Health Records Incentive Programs.

CPIA: Clinical Practice Improvement Activity
A new Medicare performance category that may help physicians gain some credit under MIPS. CPIA subcategories are expanded access, population management, care coordination, patient engagement, patient safety and practice assessment, and transition to or participation in an alternative payment model. New rules will define the criteria.

QCDR: Qualified Clinical Data Registry
An entity approved by CMS that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.

CAHPS: Consumer Assessment of Healthcare Providers and Systems
Patient satisfaction and experience surveys.

ACI: Advancing care information

APMs: Alternative payment models

CAHPS: Consumer Assessment of Healthcare Providers and Systems

CEHRT: Certified electronic health record technology

CHIP: Children's Health Insurance Program

CMS: Centers for Medicare & Medicaid Services

CPIA: Clinical practice improvement activity

CPS: Composite performance score

EHR: Electronic health record

HITECH: Health Information Technology for Economic and Clinical Health Act

IT: Information technology

MACRA: Medicare Access and CHIP Reauthorization
Act of 2015

MGMA: Medical Group Management Association

MIPS: Merit-Based Incentive Payment System

MU: Meaningful use

ONC: Office of the National Coordinator for Health Information Technology

PQRS: Physician Quality Reporting System

QCDRs: Qualified clinical data registries

SHARP: Strategic Health IT Advance Research Projects

SGR: Sustainable Growth Rate

TMA: Texas Medical Association

VM: Value-Based Payment Modifier Program

Proposed Rule: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule, 81 Fed. Reg. (May 9, 2016). *Federal Register: The Daily Journal of the United States.* https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf

Notes

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