



Physicians Caring for Texans

September 10, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

VIA ELECTRONIC SUBMISSION

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program; Proposed Rule

Dear Administrator Verma:

On behalf of our more than 51,000 physician and medical student members, the Texas Medical Association (TMA) thanks you for the opportunity to comment on the “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program” published in the *Federal Register* on Friday, July 27, 2018.

We sincerely appreciate the agency’s well-publicized goal of reducing Medicare’s paperwork requirements and increasing the amount of time physicians can spend with our patients. Unfortunately, the proposed rule falls well short of that goal. In fact, we fear that the rule will significantly increase Medicare’s administrative burden, will reduce Medicare payments to many physician practices, will do little to improve quality of care or reduce the cost of care, and will further reduce Medicare beneficiaries’ access to care.

We offer our comments, recommendations, and suggestions in the spirit of improving this 52-year-old system that covers health care costs for some 57 million Americans — including nearly 4 million Texans. As physicians responsible for delivering this care, it is our responsibility to offer our frank and constructive comments. On behalf of our patients, we ask that you favorably consider our recommendations.

PHYSICIAN FEE SCHEDULE

Overview

We appreciate the efforts that Secretary Azar and the Centers for Medicare & Medicaid Services (CMS) have made to consider the impact of current administrative burdens on physicians and how they impede patient care. You have made it clear that you want to continue moving forward on administrative simplification. We appreciate and agree with this sentiment but believe the agency missed that mark significantly in a few areas of this proposed rule. Detailed comments follow but please note that we are not commenting on various relative value unit (RVU) revisions and other changes that are specialty-specific. We urge you to consider carefully comments on these subjects from specialty societies that have particular expertise not common to all physicians.

Telehealth Expansion

CMS proposes to expand payment for newly defined services furnished through various methods of communication technology. The agency proposes to create:

1. A billable service for physicians to have a brief, non-face-to-face check-in with a patient via communication technology to assess whether the patient's condition necessitates an office visit;
2. A specific code for the remote professional evaluation of patient-transmitted information conducted via pre-recorded "store and forward" video or image technology, and
3. A separate payment for interprofessional consultations undertaken for the benefit of treating a patient.

TMA commends CMS for taking another step to modernize how care is delivered to Medicare patients. Physicians and providers have been delivering care to patients via communication technology for quite some time. Although they are not paid for it, many physicians speak with patients via phone, review images patients send electronically, and engage in interprofessional consults for the benefit of treating their patients. Many times patients check in with their physicians via phone or via sent images because they struggle with transportation and long travel distances to their physicians. We support compensating physicians for their expertise and services regardless of the method used to deliver the service. Paying physicians for these services helps to ensure continued practice viability.

We must note that we are concerned about the financial impact the above items may have on patients. Under the proposed guidelines, Medicare patients will be accountable for their cost share portion of the Medicare allowable amount for each of these services. Because of this, TMA is concerned that Medicare beneficiaries will avoid or delay care because they will be charged for a service for which they historically have been not billed. This avoidance and/or delay in care may lead to an overall increase in cost of care and decrease in patients' wellbeing. Therefore, we encourage CMS to increase its efforts to educate Medicare beneficiaries about this new policy prior to its implementation.

CMS states that it is unsure about developing and applying frequency limitations for these newly billable services. We believe that establishing limitations for the number of times a patient is allowed to initiate contact with his or her physician in this manner may create confusion for both the physician and the patient. The agency stated that these services could not:

- Originate from a related E/M service provided within the previous seven days; or
- Lead to an E/M service or procedure within 24 hours or soonest available time of the communication technology service.

This can pose a problem for physicians who are not able to see a patient for an extended period of time (i.e.: a week). In such circumstances, the telephone visit should be considered a separate visit and not part of the face to face visit. The physician provided care and expertise over the telephone to maintain the patient's health until the next appointment. Additionally, a related E/M service provided within the previous seven days may have included changes or additions to the patient's medical plan of treatment. This could include changes to medications. The patient's adjustment to those medications could be reviewed and discussed via a "virtual check-in." Establishing limitations may discourage patients' use of the services due to their concerns that they may be financially liable for the whole visit. Limitations require physicians to count the number of times each patient has utilized the service, and require reviewing past billing records to confirm they meet the two guidelines mentioned previously. This creates an administrative burden for all.

We also have concerns about obtaining consent for these services. The proposed rule was vague about the method and frequency required to obtain this consent. Additionally, it was not mentioned whether a verbal consent would be sufficient to meet existing state and federal telemedicine guidelines and what consent is needed from the patient so the service may be billed to Medicare. If verbal consent is sufficient, we are uncertain how this would be applied to "store and forward" video or image review. CMS mentions the possibility of new patients contacting physicians to request dermatology services via the "store and forward" video or image review. We have concerns about how new patients would forward images to physicians with whom they are not established. If physicians are allowed to obtain written consent once a year for all communication technology services, regardless if they are patient-initiated, TMA is concerned about confusion among Medicare beneficiaries as to what will constitute a billable telehealth service. As mentioned above, the three proposed telehealth services are similar to services physicians currently provide but have never been able to bill Medicare or the patient.

CMS was not specific about the documentation requirements or "proof" of visit for any of these new communication technology services. Before implementing these new services, the agency also must clarify what defines a "related" E/M service and what timeframe applies to the "soonest available time" after a technology service has been rendered

CMS provided no information about the technology requirements for these new services. Multiple technology options may be used to provide telehealth services. That CMS is not considering these new telehealth services to fall under its existing definition of telemedicine would lead us to believe that physicians would not have to meet the existing technology requirements. If CMS is going to establish new technology guidelines, those need to be provided

to physicians well in advance of implementation of these new services. We would be very concerned if CMS is going to establish strict guidelines that limit physicians' ability to use existing telehealth services or require physicians to obtain some type of "certification." The implementation of telehealth should help reduce physicians' administrative burdens and not create an additional financial burden on the practice.

TMA Recommendation: TMA supports the CMS initiative to offer new telehealth options that will benefit enrollees and physicians. CMS must provide more guidance in advance of rollout of these services so that physicians will be prepared to meet regulatory and billing requirements. CMS should educate patients about this new service option, including the consent process and their financial responsibilities. CMS should consider the role third party vendors will play in implementing this rule and work to make sure implementation does not create additional financial and administrative burdens for physicians.

E/M Documentation Guidelines

CMS states that its primary goal in this proposed rule is to reduce administrative burden so physicians can focus on patient care. The agency recognizes that the current documentation guidelines are outdated. For outpatient office visits, the agency proposes to offer physicians the choice of medical decision making (MDM) and time-based documentation in addition to the 1995 or 1997 framework to document the appropriate level of evaluation and management (E/M) visits. Currently, physicians have no choice but to adhere to the redundant and unnecessary documentation requirements that serve only to meet Medicare audit guideline. The requirements take time away from patients and don't benefit MDM.

This proposal simplifies documentation requirements and refocuses physician attention on medical decision making and what is needed for appropriate patient care. Physicians would no longer focus on documenting to comply with guidelines under the threat of arbitrary audits. We applaud CMS for considerable thought in how to reduce administrative burden and simplify the E/M visit documentation requirements. We agree that the current requirements for visit codes stress meaningless box checking, and we strongly support your proposal to leave the extent of history and physical documentation to physician discretion. We oppose inappropriate quantitative formulas or assignment of numeric values to determine medical record keeping. CMS should not use counting methodologies or numerical formulas as the primary reason for medical record documentation.

We fully support CMS's proposal for simplified documentation that does not burden physicians with extraneous audit requirements. The agency also proposes retaining "the current CPT coding structure for E/M visits." TMA agrees with this and believes CMS should accept higher coding levels for visits based simply on either time or evidence of medical complexity. Patient care and medical complexity, not government audits, must drive documentation.

TMA supports CMS' desire to relieve the administrative burden of excessive and overwhelming E/M documentation guidelines that has increased over the years. We concur that the E/M codes do not "reflect the complete range of services and resource costs." Physicians have needed relief from this administrative burden for many years.

We note that any substantial change to coding or documentation rules will carry significant costs and create new administrative burdens for physician practices, including costs for software updates, revisions of internal and external reports, and staff and physician training. Furthermore, software vendors, billing companies, and others who serve physician practices will need lead time to revise their products and processes. Consequently, we urge that any rule change provide for lenient transition rules and timelines.

We also are concerned about possible audit implications. The agency is now opening the door to multiple standards for documentation. While we are in support of the choices, we are concerned about how this will affect the Comprehensive Error Rate Testing (CERT) audit and the audits performed by the Recovery Audit Contractors (RAC). We are concerned about the auditors' abilities to know which documentation standard the physician chose. Each of the proposed E/M documentation standards may be used by physicians and vary based on things such as the physician's specialty or the patient's specific medical needs.

TMA Recommendation: CMS should continue to work to relieve physicians of the administrative burdens created by outdated, excessive, and overwhelming E/M documentation guidelines. This work should involve input from a variety of sources, including all specialties and a designated workgroup. Other administrative burdens still exist for physicians, including those we outline in later comments on the Quality Payment Program. Due to these additional burdens CMS should not tie the reduction in E/M documentation guidelines to any reduction in payment for E/M services.

Additional Burden Reduction and Simplification

Medicare also has proposed eliminating documentation for medical necessity for home visits. The agency states that the physician is the best person to make such decisions and additional rules are not needed.

CMS has also recognized the increasing complexities that often come with treating Medicare patients. Currently, physicians or multiple physicians in the same specialty and practice may not bill same-day visits. The agency has proposed to eliminate this policy. While this policy was created to prevent abuse, CMS recognizes that there are instances where this policy does not make sense.

As the senior population continues to expand, physicians have adapted and changed to deliver care according to their patients' needs. As such, there is often a need for a physician to see a patient for more than one encounter on the same day. Additionally, there are times where physicians in the same specialty and practice need to see patients for multiple visits on the same day.

Physicians accept the additional administrative burden of teaching while delivering patient care because they understand the importance of providing direct patient care education to residents.. CMS has recognized how it has added to this burden by requiring duplicative documentation for

E/M services while teaching residents. We appreciate that the agency has proposed to eliminate the duplicative requirement for documentation.

We applaud CMS for recognizing these opportunities to reduce administrative burden and simplify patient care. You have rightfully proposed the elimination of documentation that is excessive and redundant and acknowledged physician decision making as the fundamental source of deciding the most appropriate place, time, and type of care for patients.

TMA supports policies that empower physicians to provide the right care at the right time and in the right place. We also support any reduction to administrative burdens that obstruct or hinder patient care delivery.

TMA Recommendation: CMS should continue to prioritize simplification and reducing administrative burden. CMS should move forward with proposed documentation requirement changes for home visits and for physicians teaching residents. The agency also should move forward with allowing physicians or multiple physicians in the same specialty and practice to bill same-day E/M visits.

E/M Payment Collapse

CMS has proposed to flatten payment for E/M visits as an action corresponding to the administrative burden relief in E/M documentation guidelines. The agency proposes to continue to pay one fee for level 1 visits and a different, flat fee for visit levels 2 – 5. Physicians will still use level 2 – 5 CPT codes to bill for those services. The minimum documentation required for payment would be equal to a level 2 visit. That said, CMS expects physicians would continue to document levels 3 – 5 in accordance with the medical complexity of the visit.

CMS erroneously assumed that reducing one of many overly burdensome administrative compliance requirements necessitates a significant reduction in physician payment. In fact, this action will cause significant harm to physicians and patients. The administrative burdens of compliance with other Medicare requirements along with reporting under the Quality Payment Program and the increasing penalties associated with that program still exist and continue to make it difficult and costly for practicing physicians. Eliminating the payment differential for the visit levels will remove incentives for physicians to care for complex or complicated patients including those with disabilities and those with serious or terminal illnesses.

A significant reduction in physician payment, as is being proposed under the consolidation of payment for E/M, will mean that treating patients covered by Medicare will become even more challenging. Low payments already make participation in the Medicare program unattractive for physicians. Based on results from a 2016 TMA survey, 36 percent of Texas physicians limit access to Medicare beneficiaries. Physicians who choose to continue participating may have to limit further the number of Medicare patients they see — or stop participating in the program altogether — to maintain practice viability. Medicare patients who cannot access outpatient care will continue to drive total Medicare costs higher by seeking care in more expensive settings.

We appreciate the fact that the agency recognizes this change will reduce payments to physicians and therefore, created “add-on” codes to offset these reductions. However, as we explain further below, these codes do not provide enough compensation to offset the negative impact. Historically, Medicare has used a payment calculation based on the resourced-based relative value scale (RBRVS). The three components of this system are physician work, practice expense, and professional liability insurance. Based on the agency’s comments, a decrease in physician administrative burden equals a decrease in overall payment. Since this is the only area that will receive a decrease, one can logically conclude that the only component that should be reduced is the physician work component or work relative value unit (wRVU). While CMS is proposing to reduce the E/M documentation requirements, the amount of time, expertise, and skill used with the patient will not change. This is a significant devaluation of the physician’s work. This is a violation of the principles that relative values should reflect the relative cost of inputs. Additionally, CMS has elected to pigeon hole the “add-on” codes to apply only to three types of E/M visits. This is a further devaluation of the physician’s work, potentially based on their specialty or the service being provided at the same time as the E/M.

TMA advocates for physician payments to be accurate, fair, and adequate. We oppose this change in payment structure as it is neither accurate, fair, nor adequate.

Again, we note that any substantial change to coding or documentation rules will carry significant costs and administrative burdens for physician practices, including the costs for software updates, revisions of internal and external reports, and staff and physician training. Additionally, software vendors, billing companies, and others who serve physician practices will need lead time to revise their products and processes. Therefore, we urge that any rule change provide for lenient transition rules and timelines.

TMA Recommendation: CMS should not reduce payment for E/M visits. Nor should they tie a reduction in payment to a reduction in any of the agency’s administrative requirements, such as the E/M documentation guidelines. The physician payment structure must be accurate, fair, and adequate. TMA recommends that CMS create a workgroup of physicians and other health professionals with deep expertise in defining and valuing codes, and who also use the office visit codes to describe and bill for services provided to Medicare patients. This workgroup would analyze this further to provide solutions in the future.

“Add-on” Codes to Recognize Additional Relative Resources

Currently, physicians use one code to bill and document the complexity of service for office visits. The code used falls in a range of Level 1-5. With the proposed changes to office visit payments, CMS acknowledges its flawed methodology for flattening the payment of E/M visit levels 2 – 5. Because of the inappropriate reduction in fees for these encounters, the agency has proposed creating an “add-on” code to increase the payment for complex office visits. CMS has created two sets of codes and payment amounts, one for primary care physicians and one for other specialists.

This proposed change adds complexity to existing overly complex administrative requirements. The currently used code set is widely accepted throughout the industry and used by all

physicians and payers. Creating these two “add-on” codes to be used only by Medicare creates an additional burden. Physicians will have to apply different guidelines to code for Medicare services. This cannot be what was meant when this administration called for administrative simplification or “patients over paperwork.”

The required documentation and reasoning for these “add-on” codes were not clearly described in the proposal. We are concerned about the expectations for use of these new codes. Such vague requirements very well might open the door for an increase in audits and additional scrutiny.

Additionally, the Social Security Act 1848 (c)(6) states that the “Secretary may not vary the conversion factor or the number of relative value units for a physicians’ service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.”

We are concerned that this proposed rule violates the Social Security Act with the addition of these specialty specific “add-on” codes. Separate “add-on” codes with different relative values should not be created to compensate certain specialists differently from others, including primary care specialists.

TMA opposes the creation of “add-on” codes that simply support flawed payment methodologies and create more administrative burdens. These codes will not reverse the harm created with the flattening of the level 2-5 office visit payment. With these changes, it is likely that more physicians will limit their acceptance of Medicare patients.

As mentioned earlier, any substantial change to coding or documentation rules will carry significant costs and administrative burdens for physician practices. At the same time, software vendors, billing companies, and others who serve physician practices will need lead time to revise their products and processes. Again, we urge that any rule change provides for lenient transition rules and timelines.

As noted above, we urge you to carefully consider comments from specialty societies on these subjects where they have particular expertise not common to all physicians.

TMA Recommendation: CMS should not create “add-on” codes that support flawed payment methodologies and increase the administrative burdens associated with coding and billing under the Medicare program. These codes will not reverse the harm created with the flattening of the level 2-5 office visit payments.

Multiple Procedure Payment Reduction (MPPR)

CMS’ current MPPR policy applies when physicians bill more than one procedure for the same patient on the same day. The agency has decided to expand this payment reduction to E/M codes for standalone office visits provided on the same day as a procedure. CMS proposes this reduction because it believes there is a “significant overlapping resource costs.”

In addition to our opposition of further selective fee reductions, TMA opposes the practice of downcoding and bundling care physicians provide. CMS estimates a savings of 6.7 million RVU's with this reduction. However, there would be a significant unintended consequence of such a proposal, In light of such a significant and unsustainable loss, physicians would be required to conduct patient procedures on separate days from office visits..

TMA Recommendation: CMS should not make further selective fee reductions, downcode, or bundle care physicians provide.

Geographic Pricing Cost Index (GPCIs)

We continue to be extremely unhappy that Medicare is still not acting to revise payment locality boundaries in spite of recommendations by the Government Accountability Office, by the Institute of Medicine, and by repeated studies of the problems with the current localities. The failure of CMS to revise payment localities has increasingly distorted the payment system as urban areas have grown and local cost factors have changed dramatically. The fact that California has now sought legislative intervention to attain locality revisions does not solve the problem, but illustrates its importance and highlights the urgency. The GPCIs cannot be accurate or meaningful until localities are revised. We believe that large cuts to rural and rest-of-state areas should be avoided or minimized, but locality boundaries with large payment differences should not be in the middle of urban areas. In many areas of Texas, locality boundaries that currently fall within seamless urban areas create “payment cliffs” where payment can change by up to 8 percent if an office location is moved across a street or down a block. For the next GPCI update to produce accurate and fair geographic adjustments, CMS must act immediately to create locality definitions that are not constrained by the current county boundaries. We advocate implementing locality definitions based on Metropolitan Statistical Areas (MSA) or on hospital localities or on similar methodology recommended in the many past or ongoing studies. Because the locality updates have been delayed so long, new values should be phased-in over two or more years to reduce any sudden negative impacts. In the future, payment localities should be updated regularly so that population changes do not reintroduce these payment distortions.

TMA Recommendation: TMA recommends that CMS immediately revise the payment localities used in the GPCI calculations. Using MSAs to determine the boundary changes is the most logical and expedient way to improve this calculation. We also continue to recommend that CMS reevaluate existing databases to find or develop a nationwide measure of commercial office rents for use in calculating practice expense GPCIs.

General Fee Update

We understand that Medicare fee updates are controlled by congressional action, but we are very disappointed that the fee updates that were ostensibly promised in MACRA will again not be forthcoming. We are concerned that the recent history of and future plans for inadequate fee updates, paired with the growing Medicare administrative burden, is making Medicare participation and compliance increasing difficult and costly for practicing physicians, and will impair access to care for Medicare beneficiaries. Although general operating cost growth has been low in recent years, it has not been zero. Continuing failure to increase payment

commensurate with cost increases is creating significant decreases in Medicare payment adequacy. Medicare estimates market-basket cost increases in calculating a Medicare Economic Index, which historically has increased approximately 2 percent per year. The MEI is used in calculating fee updates for hospitals, nursing homes, and other facilities, to ensure that their cost increases are covered. The same standard should apply to physician payment.

Increases in administrative complexity are making Medicare participation an increasingly unattractive proposition to the smaller sized practices common in Texas. Although regulatory action cannot override congressional provisions with regard to fees, CMS should continue to prioritize reductions in administrative cost burdens to avoid exacerbating the problem of low and declining Medicare payments. Although almost all physicians will treat some Medicare beneficiaries, even if only when they take emergency room call, 36 percent of Texas physicians report that they now have limits on accepting new Medicare patients. Continuing to add administrative burden without increasing fees commensurately will mean that treating Medicare patients will become increasingly unsustainable and Medicare business increasingly unattractive for physicians. Medicare beneficiaries who cannot access outpatient physician care will increasingly seek care in emergency rooms, driving total Medicare cost higher.

TMA Recommendation: CMS should continue to make every possible effort in all rulemaking to decrease administrative cost burdens for physicians to offset the adverse impact of inadequate fees and rising costs.

Off-campus Hospital Payments

TMA supports all CMS efforts to equalize total payments for the same services delivered in facility versus non-facility sites. We understand the complexity of the fee reduction calculations that you are undertaking and urge you to continue your efforts to neutralize the current incentives for physicians to move out of community-based independent practice into larger facility-controlled settings. We would suggest that, rather than applying downward adjustments to facility payments, it might be far simpler to pay for most services, including outpatient E/M visits, using the physician fee schedule (PFS) coding and payment amounts, even when those services are delivered in a facility-related site. If additional services are provided during the outpatient visit, as you suggest would sometimes be the case, those services also should be billed and paid using PFS rules. In any case, we urge you to continue your efforts to equalize payments across all delivery settings, to avoid incentives for wasteful changes of delivery settings undertaken simply to maximize payment.

TMA Recommendation: CMS should continue its efforts to equalize payments across all delivery settings to avoid incentives for wasteful changes of delivery settings undertaken simply to maximize payment. This should be done by using the physician fee schedule (PFS) coding and payment amounts instead of complex fee reduction calculations. When adjuvant services are required, they also should be paid according to PFS rules.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging

In contrast to other efforts that CMS is making to reduce administrative burden on physicians, the required use of specific clinical decision support mechanisms (CDSMs) and the required reporting on claims adds considerably to the regulatory cost burden on physician practice. The administrative burdens include the costs to purchase or subscribe to specific proprietary CDSM products, the costs to build or incorporate software interfaces for those products, the costs of revising referral processes to ensure that the required information is transmitted from the ordering to the referring physicians, the costs to revise claim filing processes and software, and the costs for physician and staff training for both ordering and referring physicians. We continue to be very concerned that the total cost of implementing these processes for all physicians far exceeds any possible benefit in the form of reduction in over-utilization. If there is some evidence suggesting that specific Medicare providers are using advanced diagnostic imaging inappropriately, the required use of CDSMs should be targeted specifically to the suspected abusers.

While the agency has made some modifications to the program they do not alleviate the enormous process and cost burden this regulation imposes on physician practices. The changes to the significant hardship exceptions do not address the hardship incurred by small practices to comply with this rule. While we can appreciate including auxiliary personnel to perform and document the AUC consult on behalf of the ordering physicians, it does not change the fact that this still adds, time, cost, and administrative burden to the practice. This proposed rule can be equated to using a sledge hammer to crack a nut.

We continue to oppose adding material administrative burden on all physicians and providers to change the behavior of a minority who may be referring inappropriately. We continue to support the inclusion of CDSM in the list of activities that are incentivized in the Quality Payment Program. If CMS concludes that it does not have the statutory latitude to limit the scope of these requirements to target abusers, we request that any broad implementation be accompanied by appropriate studies to evaluate the cost versus benefit. The goal of such studies would be limiting future requirements and administrative burden to a targeted subset of physicians and providers or to circumstances that have been shown by the study data to carry a material risk of program overuse.

TMA Recommendation: In light of its Patients over Paperwork Initiative, CMS should use every tool in its wheelhouse to mitigate the material administrative burden this rule creates. CMS should evaluate existing data so that it is able to target a subset of physicians or providers, or circumstances that have been shown to carry a material risk of program overuse.

Price Transparency

Next, CMS requests information on price transparency and improving beneficiary access to physician, provider, and supplier charge information. More specifically, CMS states, in part:

We are concerned that challenges continue to exist for patients due to insufficient price transparency. Such challenges include patients being surprised by out-of-network bills for physicians, such as anesthesiologists and radiologists, who

provide services at in-network hospitals and in other settings, and patients being surprised by facility fees, physician fees for emergency department visits, or by fees for providers and suppliers that are part of an episode of care but that were not furnished by the hospital. We are concerned that, for providers and suppliers that maintain a list of standard charges, the charge data may not be helpful to patients for determining what they are likely to pay for a particular service or facility encounter. In order to promote greater price transparency for patients, we are considering ways to improve the accessibility and usability of current charge information.

While TMA agrees that price transparency is worthy of further discussion and review by CMS *as applied to the Medicare program*, we have serious concerns with the expansive phrasing of CMS' request for information on price transparency. As demonstrated by the excerpt noted above (as well as many of the specific questions posed by CMS), the agency appears to be requesting information that may be more useful for consumers covered under an individual or employer policy than those covered under Medicare.

We urge CMS to acknowledge that, due to the existing framework of the Medicare program, the price transparency needs of Medicare enrollees differ in many respects from those other consumers. For example, the above excerpt uses the phrase "out-of-network bills." However, as CMS is aware, a provider is either a Medicare provider or has opted out. But, either way, in contrast to private PPO coverage, there is no balance billing in the Medicare program.

For privately insured and uninsured individuals, many states (including Texas) have taken steps to develop price transparency legislation that best fits the needs of their residents; however, due to the complexity of the issue, there are wide variations in those approaches. From an operational and administrative burden standpoint, there are many challenges related to price transparency.

When a service or procedure is planned in advance, most Texas physician practices make efforts to give their own pricing information or, to the extent possible, relevant out-of-pocket cost information to patients. This applies to all patients, regardless of their health care coverage. Doing so is a best business practice, because it improves the collectability of patient-owed amounts and decreases bad debt. Furthermore, if a physician practice can collect any out-of-pocket costs at the time of the visit or procedure, it reduces the administrative costs of billing and collecting, allowing the practice to run more profitably.

Consequently, most Texas physicians report that they try to give some relevant price or out-of-pocket cost information to patients; **however, physicians are limited in their ability to do so.** Three examples of limiting factors are the following:

- Uncertainty about the specific details of the service or procedure(s) to be provided make advance disclosures difficult. Each patient is unique, and his or her medical needs and treatment plan are consequently unique. The patient's specific health care needs also are constantly evolving and may not be easily determined in advance. A patient may present with one concern and ultimately need treatment for a host of other conditions that are detected during the course of treatment.

- Complexity of the billing/coding system further limits a physician's ability to disclose useful information in advance. This is common even for office visits, as unanticipated diagnostic testing and procedures may be performed. Insurance medical and payment policies, prior authorization requirements, and referral requirements add additional barriers.
- When patients seek emergency services, EMTALA prohibits delay of an appropriate medical screening examination or stabilization in order to inquire about the patient's method of payment or possible insurance coverage.

These limitations impact *all* patients covered under a health plan, including Medicare enrollees.

Variations in insurance products, including Medigap plans, also makes disclosure of useful pricing information difficult. When no insurer or insurance contract is involved in the transaction, giving the patient pricing information is simple. The physician is wholly in control of his own prices (i.e., his charges) and billing practices. When an insurer is involved, the price and specific health coverage guidelines create complexity. Contracts between insurers and physicians generally set allowable prices that replace the physician's standard fee schedule. The allowable amounts set by the insurer may change yearly, quarterly, or more frequently and may occur without advance consent. The price that the patient pays may not be in the physician's control and not even known to the physician. Patient's out-of-pocket costs will vary based on the specific insurer rules related to the type of coverage the patient has. These variations impact copayment and coinsurance amounts, the deductible amount, and what amount, if any, has been met under the deductible rules. In addition, the added complexity of narrow networks created by health plans makes determining the network status of physicians difficult to determine. The insurer may be the only party that has all the detailed information needed to calculate the amount the patient may need to pay the physician. Physicians make attempts to obtain this information for their patients but frequently report they are unable to get specific information or any information at all.

When a patient is covered under traditional Medicare, price and specific health coverage guidelines are more transparent. All Medicare enrollees have the same deductible and cost share amount. Additionally, coverage guidelines are sometimes more accessible, and the patient's cost share information is clearly defined. Unfortunately, though, with the increasing number of Medicare enrollees choosing Medicare Advantage (MA) products, more Medicare enrollees may experience the issues previously mentioned regarding variations in insurance products. Contracts between the MA insurers and physicians set allowable prices that differ from the Medicare fee schedule amounts. In addition, CMS guidelines allow MA plans to implement prior authorization requirements for health care services. CMS' recent decision to allow for step therapy adds additional complexity. Those requirements create more barriers to obtaining accurate payment information for patients and add to the physician's administrative burden.

In recognition of all of the challenges set forth above, TMA recommends that CMS take more time to deliberate any next steps on meaningful price transparency in the Medicare program. Price transparency is a complex topic that should not be shoe-horned into a Medicare fee

schedule rule proposal. Before CMS moves forward with any new price transparency initiatives, further stakeholder input will be imperative.

CMS also should: 1) be mindful to narrowly focus its price transparency efforts to meet the needs of Medicare enrollees; 2) acknowledge there are significant limitations as to what a physician or provider may know or be able to disclose; 3) work with all stakeholders – physicians, hospitals and other providers, patients, insurers, employers, and government payers – while developing solutions to price transparency, and 4) carefully consider the operational challenges and administrative burdens associated with any next step contemplated on price transparency.

TMA also seeks clarification from CMS on its question about requiring physicians, providers, and suppliers to provide patients with information on what Medicare pays for a particular service. As CMS is aware, Medicare payment amounts are available for anyone to view. Is CMS proposing that the Medicare payment amount be provided to all patients, regardless of whether they are covered under Medicare? If so, TMA strongly objects because using Medicare or Medicaid data to inform consumers would be deceptive. As CMS is aware, Medicare physician fees are federal price controls, not market prices. Additionally, Medicare fees measured in real dollars have decreased by 25 percent since 2001.

TMA Recommendation: TMA urges CMS to avoid moving forward hastily with any new price transparency effort, as there is great potential for imposing undue burdens on physicians and providers by requiring disclosure of information that may be of little-to-no utility to Medicare enrollees. CMS must work with all stakeholders while developing new price transparency policies for Medicare enrollees as well as consumers covered under an individual or employer policy.

QUALITY PAYMENT PROGRAM

Overview

TMA appreciates the opportunity to comment on the proposed updates to the 2019 Quality Payment Program (QPP) to implement the provisions set forth by the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA). TMA is pleased with the agency's proposal to maintain the low-volume threshold and introduce a new component that would allow physicians who otherwise would be excluded to opt-in. In fact, to better support physicians in their move to value-based care, we believe participation in the entire program should be voluntary. Unfortunately, our overall analysis otherwise found no significant improvement or simplification to alleviate the administrative and cost burdens associated with the integrated policies of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) under the QPP. Contrary to MACRA and congressional intent, we continue to find these new programs to be even more administratively complex than their predecessors.

Although TMA appreciates the agency's proposals to improve interoperability of electronic health record (EHR) technology and reduce documentation requirements through its Patients

over Paperwork Initiative, we believe that the overall documentation required under the QPP contradicts the agency's new priority of creating a health care system that increases the amount of time that physicians spend with their patients while reducing the burden of paperwork. We remind CMS that with each measure, objective, and improvement activity it subjects physicians to under the QPP, physicians must spend more time on paperwork to document every aspect of clinical care delivery that corresponds to the data elements that support each metric. QPP requirements call for detailed documentation so that physicians will be able to provide substantive, primary source documents as proof in the event they are selected for mandatory audits by the agency. Exacerbating this burden, current CMS policies require clinical data for all patients regardless of payer, including Medicaid and private-payers. This forces physicians to document QPP-related data for both Medicare and non-Medicare beneficiaries either through electronic means or paper charts on a daily basis.

While we acknowledge that many physician practices are in a position to engage in full participation, we continue to hear from even more physicians who are neither ready nor have the time and resources to take on and manage the additional administrative, technological, and financial challenges associated with the QPP while being subject to annual Medicare payment penalties due to nonparticipation. Given that TMA 2016 survey data showed that 73 percent of Texas physicians work in practices of eight or fewer physicians, and because the majority of physicians will continue to participate in MIPS rather than APMs, we are particularly concerned that the QPP as currently designed will continue to harm solo and small practices in our state. As evidenced by the agency's estimates of the proposed rule, incentive payments for larger practices will continue to be funded in large part by physicians in smaller practices. Thus, many of the agency's policies that govern the QPP result in disparities among practices and inequitable payment incentives that are bad for medicine and demoralizing to the profession during a time when physician burnout attributed to heavy regulatory burdens is at an all-time high.

As we move into the third year of the QPP, TMA continues to be concerned that the compliance, documentation, and data submission requirements required by law and regulation are costly and wasteful with no proven evidence of benefit. The requirements and incentives may even have the counterproductive effect of reducing access to good ambulatory care for many Medicare beneficiaries. We encourage CMS to counter medicine's serious concerns with program data and sound evidence that show whether the QPP is meeting its aims as envisioned by MACRA and Congress, such as improving the care and population health of Medicare beneficiaries, lowering Medicare costs, and minimizing burden on practicing physicians.

Due to the aforementioned reasons and because the payment penalty for the 2021 payment year will increase to 7 percent and then cap at 9 percent the following year, TMA urges CMS to make significant improvements and simplify the QPP for the 2019 performance year and beyond. Specifically, we seek policies that facilitate a value-based payment system that: 1) ensures quality of care, 2) fosters the patient-physician relationship, 3) offers voluntary physician participation, 4) uses accurate data and fair reporting, 5) provides fair and equitable program incentives, and 6) decreases administrative and cost burdens for all physicians.

Furthermore, we understand that the ultimate solution to many of these program design problems will require congressional action to amend MACRA or other statutes, but we urge you to continue to use your regulatory authority to mitigate the negative impact in every way possible.

Our detailed comments follow. Again, please note that generally we are not commenting on issues that are specific to certain medical specialties. We urge you to carefully consider comments from specialty physicians on those subjects where they have particular expertise not common to all physicians.

General Program Concerns

Cost of Reporting Requirements

We continue to be concerned that the compliance, documentation, and reporting necessary to score well in the QPP are prohibitively costly for many physicians. These include the costs to learn program requirements; re-learn after annual program revisions; investigate reporting options and requirements; select compliance methods; purchase memberships, software, upgrades, or services; 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. Many of these costs are subject to economies of scale, so that they become cost-effective only for larger physician groups. Given that the “pick your pace” policies applied only to the 2017 transition year, physicians and groups now must engage in full data reporting across all MIPS categories. For many physicians and groups, the compliance costs required to attempt to earn incentives will exceed the value of those incentives and are unlikely to see a positive return on investment.

TMA Recommendation: CMS should continue efforts to streamline and simplify all reporting and compliance requirements, as well as develop a no- to low-cost data collection and reporting system for the QPP.

Measured Results are Not in Physician Control

By statute, MIPS scores are aggregated from four different categories: quality, cost, improvement activities, and promoting interoperability (PI). Of these four areas, the improvement activities category may be the only one for which physicians wield substantial control over their own performance. Attribution and measurement problems in the cost category hold physicians responsible for costs that are unrelated to any of their own services, recommendations, or orders, and over which they have no control. Many of the proxy measures used to assess quality are highly dependent on patient actions and choices, because patients choose whether to accept physician direction or advice. Depending on the circumstances, physician efforts to influence or modify patient decision-making may be costly but have little or no possibility of attaining the desired results. Locus of control over many PI standards and requirements may rest with vendors, not physicians.

TMA Recommendation: CMS should eliminate measures based on actions or outcomes that are not in physician control.

Penalties for Serving Specific Patient Groups

Patient demographic factors that relate to high cost or resource use, poor outcomes, or have adverse effects on other quality measures are not evenly distributed across the population. Many patient actions and decisions correlate more strongly to demographic or socioeconomic variables, or to local access to care issues than to physician efforts or actions. Studies have shown that poverty and lack of education are correlated with poor health outcomes, even when access to health care is universally available.¹

Patient demographic variables including gender and ethnicity have been shown to be related to medication compliance;² and racial, religious, or cultural variables affect patient preferences for care including end-of-life choices about intensive care and resuscitation.³ 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 cost and quality scores that are adversely affected by these variables financially penalize the physicians who serve disproportionate numbers of patients from certain population subgroups, including specific racial or cultural groups and patients who have lived a lifetime of poverty without access to good medical care. Furthermore, local access to care variables such as poor physician supply or transportation distances also can affect outcomes by reducing access to routine ambulatory care and increasing use of more costly hospital-based care. Penalizing physicians who offer services in these localities is counter-productive.

TMA Recommendation: CMS should eliminate measures that penalize physicians who disproportionately treat patients of disadvantaged populations. If this is not possible, CMS should make the program completely voluntary.

Risk Adjustment

It is clear that Congress did not intend to penalize physicians who care for large numbers of economically disadvantaged or minority patients, but the current measures 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. In fact, Congress repeatedly has incorporated calls for appropriate risk adjustment on both cost and quality measures, including the following provision in MACRA law:

“(G) ACCOUNTING FOR RISK FACTORS.—

¹ Alter, D., Stukel, T.A., Chong, A., & Henry, D. (2011). Lesson from Canada's Universal Care: socially disadvantaged patients use more health services, still have poorer health. *Health affairs*, 30 2, 274-83. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2009.0669>

² Ellis, J.J., Erickson, S.R., Stevenson, J.G. et al. *J Gen Intern Med* (2004) 19: 638. <https://doi.org/10.1111/j.1525-1497.2004.30516.x>.

³ McKinley, E.D., Garrett, J.M., Evans, A.T. et al. *J Gen Intern Med* (1996) 11: 651. <https://doi.org/10.1007/BF02600155>

(i) RISK FACTORS.—Taking into account the relevant studies conducted and recommendations made in reports under section 2(d) of the Improving Medicare Post-Acute Care Transformation Act of 2014, and, as appropriate, other information, including information collected before completion of such studies and recommendations, the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate and based on an individual’s health status and other risk factors—

“(I) assess appropriate adjustments to quality measures, resource use measures, and other measures used under the MIPS; and

“(II) assess and implement appropriate adjustments to payment adjustments, composite performance scores, scores for performance categories, or scores for measures or activities under the MIPS.”

We are very disappointed that the several studies already completed have not yet resulted in actionable methodologies for properly risk adjusting the affected MIPS cost and quality measures. Although we appreciate the temporary bonuses proposed, they are not adequate substitutes for methodologies that could make the relevant measures fair for everyone.

We would note that the difficulty of developing proper risk adjustment methodology for patient data is an added reason that we oppose any use of all-payer data. While risk adjustment for the Medicare population is proving to be difficult, doing so for non-Medicare populations may be impossible.

TMA Recommendation: TMA continues to recommend that unless CMS can eliminate measures that are impacted by patient demographics, CMS must act immediately to implement or improve statutorily required risk adjustment for both cost and quality measures.

MERIT-BASED INCENTIVE PAYMENT SYSTEM

Policy Priorities

Low Volume Threshold

CMS has proposed changes to the low-volume threshold policy for the MIPS program. For the 2019 performance year and future years, physicians and groups now must meet at least two of three criteria in order to be included in MIPS. While the Medicare payment amount and patient count criteria are the same as prior year requirements, CMS proposes to add a third criterion of furnishing more than 200 covered professional services to Part B Medicare patients. Below are the three criteria CMS proposes to use during the MIPS determination period.

1. Allowed charges for covered professional services more than \$90,000;
2. Furnishes covered professional services to more than 200 Medicare Part B-enrolled individuals; and
3. Furnishes more than 200 covered professional services to Medicare Part B-enrolled individuals (new criterion).

The agency states that no additional clinicians would be excluded by adding the third criterion. Instead, the new criterion would simply allow the opportunity to opt-in to clinicians who otherwise would be excluded. CMS also proposes to allow clinicians who meet one or two, but not all, three criteria to opt-in, voluntarily report, or not participate.

The agency states that the difference between opt-in and voluntary participation is that clinicians who “opt-in” would be: 1) considered MIPS-eligible clinicians, 2) able to report at the individual, group, or virtual group level, and 3) subject to the MIPS payment adjustment (Medicare bonus or penalty). Whereas clinicians who “voluntarily” report would: 1) not be considered MIPS-eligible clinicians, 2) be able to report only at the individual or group level, and 3) not be eligible for the MIPS payment adjustment. For the 2019 MIPS performance year, CMS estimates approximately 42,000 clinicians nationally would opt-in under the revised low-volume threshold policy.

The agency provides the following scenarios if the opt-in policy was finalized:

Low-Volume Threshold Determination Opt-In Scenarios

Beneficiaries	Dollars	Covered Professional Services	Eligible for Opt-in
≤200	≤90K	≤200	Excluded, Not Eligible to Opt-in
≤200	≤90K	>200	Eligible to Opt-in, Voluntarily Report, or Not Participate
≤200	>90K	≤200	Eligible to Opt-in, Voluntarily Report, or Not Participate
>200	≤90K	>200	Eligible to Opt-in, Voluntarily Report, or Not Participate
>200	>90K	>200	Not eligible to Opt-in, Required to Participate

We applaud the administrator for maintaining the criteria of \$90,000 in charges and 200 Medicare patients. Additionally, we support adding a third criterion and making participation optional for those who meet at least one of the three criteria. However, it is imperative to remember that for practices with a low volume of Medicare payments, the cost of reporting far exceeds any possible benefit from incentives earned or penalties avoided.

TMA continues to recommend that this program be completely voluntary.

TMA Recommendation: The administrator should continue to maintain the two criteria from the 2018 performance year. We agree with the third low-volume threshold criterion and offering an opt-in option. TMA continues to advocate that the QPP be voluntary.

MIPS Performance Period

In the 2018 QPP final rule, the agency finalized 12-month performance periods for the 2019 MIPS quality and cost categories, and a minimum of a continuous 90-day period up to and

including the full calendar year for the 2019 MIPS PI and improvement activities categories. The agency now seeks comments about the performance periods for 2020 and future years of the QPP.

TMA reminds CMS that the agency did not inform physicians about their MIPS participation status until well after the performance year had begun in both 2017 and 2018, and will likely follow the same pattern in 2019. We believe notifying physicians and groups four to five months after the performance period has begun is too late to make adequate preparations for data collection and reporting and the necessary changes to clinical delivery for each performance measure and improvement activity required under MIPS. In addition, TMA believes finalizing current policy that requires physicians and groups to report data representing a full 12-months is premature and does not foster a gradual transition to MIPS. This is especially true for many of the physicians and groups in the 53 disaster-designated counties in our state that were effectively exempt from MIPS participation in 2017 due to Hurricane Harvey. For many of them, depending on where they fall under the revised low-volume threshold policy, the 2018 or 2019 performance year would be their first year of participation. In addition, we disagree that a full calendar year for quality and cost categories would be less confusing and burdensome for physician practices when the agency is proposing to continue to require a 90-day period for the PI and improvement activities categories.

In addition, CMS proposes to require physicians and groups to transition to the 2015 edition of certified EHR technology (CEHRT). We believe the required upgrade will cause practice disruption and could hinder meeting full-year data collection and reporting requirements, especially if the practice uses its EHR for quality reporting. In support of physician choice, we continue to oppose mandated 12-month performance periods and instead, recommend that physicians and groups determine their own performance period (90 days or up to 12 months) for each of the MIPS performance categories that require data submission. This flexibility would foster a higher degree of physician engagement and decrease burdens because it would allow physicians to determine their own performance period according to their practice readiness, chosen measures and activities, and the capabilities of their CEHRT. It also would provide them with additional time to coordinate data collection with MIPS-related vendors.

We acknowledge that CMS reports a 91-percent participation rate for the 2017 MIPS performance year, but we note that as of August 2018 the agency had not published any data describing the extent of physician engagement for the first performance year. For example, before supporting a mandated 12-month performance period for any of the MIPS categories, TMA would like to make an informed decision based on evidence that the majority of physicians in our state meaningfully engaged in MIPS and are capable of and willing to report data for a full calendar year without being adversely affected by a longer performance period.

In particular, we would like to know how many physicians and groups in Texas participated in the 2017 MIPS performance year and reported data using the test or “bare minimum” option (such as one quality measure for one patient), the 90-day option, or 12-month option. How many did not participate and received a payment penalty? How many in the 53 disaster-designated counties automatically received a final score that was equal to the performance threshold and received a neutral MIPS payment adjustment due to Hurricane Harvey? Further, we would like

to evaluate participation and performance rates by practice size, specialty, and data submission mechanisms, among other data and program results. Until such data are provided and the public and physicians have sufficient time to evaluate the results and are offered a comment period, CMS should not mandate a 12-month performance period for any of the MIPS categories.

TMA Recommendation: To help physicians and groups adequately prepare for each performance year, CMS should notify them of their participation statuses before each performance year. To support physician choice, the agency should allow physicians and groups to determine their own MIPS performance period, from 90 days or up to a full calendar year.

MIPS Performance Threshold and Additional Performance Threshold for Exceptional Performance

CMS proposes a performance threshold of 30 points for the 2019 performance year. The agency states it is a modest increase over the 2018 performance threshold of 15 points. CMS also proposes to increase the additional performance threshold for exceptional performance from 70 points to 80 points.

For the 2018 performance year, physicians and groups experienced a significant increase from 3 points to 15 points for the performance threshold. The 2018 threshold is five times more than the prior year. Doubling the threshold score for 2019 by no means equates to a “modest” increase.

TMA opposes doubling the threshold and recommends increasing the threshold by no more than 5 points for the 2019 performance year. This will create a base of 20 points that must be achieved to avoid any penalties. This gradual increase will allow continued ramp up over the next three years as set forth by the Bipartisan Budget Act of 2018.

TMA also opposes increasing the additional performance threshold for exceptional performance to 80 points. We are concerned that a higher threshold will keep physicians in solo and small practices who may not have extra staff dedicated to managing their MIPS data, additional resources, and/or advanced and sophisticated data systems that facilitate strategic data submissions from earning an additional incentive. Given that CMS has not published any data on how physicians fared on the MIPS 0-100 point scale in 2017, we are unable to make an informed decision as to an appropriate increase in 2019. For example, using 2017 performance data, how many physicians by practice size would be shut out from the exceptional performance bonus due to this 10-point increase? In determining the threshold, we recommend that CMS consider the impact a threshold of 80 points would have on smaller practices as compared to larger practices and then set a fair threshold.

TMA Recommendation: In support of a gradual increase, CMS should not increase the performance threshold to 30 points nor increase the additional performance threshold to 80 points. At most, the performance threshold should be increased by no more than 5 points and the additional performance threshold for exceptional performance should be set at a level that is fair for all physicians.

MIPS Category Weights and Contributions to Final Score

In general, the MIPS final score is currently calculated as 50 percent for the quality category, 25 percent for the PI category, 15 percent for the improvement activities category, and 10 percent for the cost category. We understand that these weights are default weights and can be adjusted in certain circumstances. Due to the technical amendments made to MACRA by the Bipartisan Budget Act of 2018, current law requires a contribution “not less than 10 percent and not more than 30 percent” for the cost category through the fifth year of the MIPS program. By law, with every percentage increase made to the cost category, the quality category will decrease until each category contributes 30 percent to the final score.

Because the agency proposes to increase the cost category weight to 15 percent next year, it proposes to amend the quality category weight from 50 percent to 45 percent while keeping the weights for the other categories the same, as required by law. Given that many problems continue to surround the cost category, such as lack of adequate risk adjustment methodologies that account for factors out of physician control, TMA strongly opposes an increase to the cost category weight until improvements are made. Therefore, we also oppose decreasing the quality weight and instead, recommend making no changes in any of the category weights for the third year of the MIPS program.

TMA Recommendation: To support a gradual transition and until CMS improves its measures and policies for the cost category, CMS should make no changes to the MIPS category weights.

Quality Performance Category

Quality Performance Category Measures and Reporting

Currently, CMS allows physicians and groups to submit data via multiple mechanisms for MIPS, but limits submissions to only one mechanism per performance category. In the 2018 QPP final rule, CMS changed the policy so that beginning with the 2019 performance year, physicians may submit data on quality measures via multiple data submission mechanisms. Physicians who have fewer than the required number of measures applicable and available under one submission mechanism may submit data on additional measures via one or more additional submission mechanism as necessary, but they are not required to do so.

Because this flexibility has cost implications and is cost prohibitive and/or administratively burdensome for some practices, we reiterate that CMS must keep this option strictly voluntary in 2019 and future years of the QPP. TMA appreciates this policy as it would allow physicians and groups an opportunity to receive the maximum number of points for the quality category. However, we continue to note that due to an insufficient number of quality measures, some physicians would not have the same opportunity to take advantage of this policy. For this reason, TMA urges the agency to reevaluate and change its scoring policies for the affected physicians, especially for those who are only able to report for the quality category using one mechanism due to insufficient measures and/or cost burdens.

TMA Recommendation: To minimize program complexity, reporting via multiple data submission mechanisms should always remain voluntary. To promote program fairness, TMA urges the agency to reevaluate and change its scoring policies for affected physicians who do not have the same opportunity to report on multiple measures and data submission mechanisms due to insufficient measures and/or cost burdens.

Identifying Applicable Measures for the Quality Performance Category

TMA offers comments about experiences shared by physicians when selecting their measures for the quality category. Some physicians and groups report having difficulty identifying with certainty what the agency determines as “applicable measures” versus what they determine as meaningful measures. For example, many physician specialists do not believe the tobacco screening and cessation intervention measure applies to them because they do not find that measure meaningful because they believe that measure applies only to primary care physicians. Then they find out later that CMS indeed deemed it as an applicable measure for their specialty.

Separate from the quality measures tool on the QPP website, to help physicians identify all applicable measures for each performance year, TMA suggests that CMS consider a new process that would help physicians and groups identify applicable measures before each performance year rather than subject them to the validation process after they have reported data on quality measures for a given performance year. This would help physicians and groups make informed decisions about all of their measure options and minimize confusion, frustration, zero points for measures that should have been reported, and/or missed opportunities for the quality category.

TMA Recommendation: To help physicians and groups make informed decisions about the MIPS quality category, TMA recommends the agency inform them before each performance year about which quality measures per data submission mechanism the agency deems as “applicable measures” for the upcoming performance year.

Collection Types, Submission Types, and Submitter Types

For the MIPS quality category, physicians and groups can elect from among six data submission mechanisms to report their quality measures data: 1) Medicare Part B claims, 2) qualified registries, 3) qualified clinical data registries (QCDRs), 4) EHR, 5) CMS web interface, and 6) the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey. The agency proposes to eliminate or revise current terms used to describe quality measures, data submission mechanisms, and submission processes and replace them with new terminology such as collection type, submitter type, submission type, direct, log in and upload, and log in and attest. The agency also proposes to rename quality measures according to their submission mechanism along with introducing new acronyms.

While TMA appreciates the agency’s efforts to add perceived clarity and precision to the MIPS program by revising existing and defining new terms that make sense to CMS administrators, we caution that any change in terminology likely would result in confusion and frustration among physicians and groups. For this reason, we disagree that these proposals would enhance the data

submission experience for physicians and strongly oppose any change to the current terminology used in the quality category and MIPS program in general.

TMA Recommendation: To foster program consistency and minimize program complexity and physician confusion with annual changes to program terminology, CMS should not revise the terms used to describe its quality measures, data submission mechanisms, and submission processes.

Medicare Part B Claims Reporting

CMS proposes amending data submission policies to make Medicare Part B claims reporting available to physicians in small group practices rather than limiting this option to solo physicians or physicians reporting at the individual level. Given that small practices continue to face numerous other challenges with MIPS participation, TMA supports the agency's proposal and agrees that this mechanism should be made available to small practices who choose to report data on quality measures through Medicare Part B claims at the group level. However, because we also support physician choice in selecting the data submission mechanism best suited for their practice, TMA recommends the Medicare Part B claims reporting option be made available to all groups regardless of practice size.

We remind CMS that to meet data completeness criteria for the claims submission mechanism, physicians must first review the measure specifications for each chosen measure, obtain the most current quality data codes (QDCs) per measure, and start reporting QDCs on Medicare Part B claims billings *at the start* of the performance year to ensure they meet reporting thresholds for eligible instances per measure and other data submission criteria. However, for the first performance year, the agency did not publish a guide for this method until October 2017. For the second performance year, the agency published a guide in late August 2018. Given that CMS requires physicians to submit data accurately for a full 12-month period in 2018 or face low quality scores and/or potential payment penalties for not meeting data completeness requirements and submission criteria, TMA believes that publishing guides this late in the performance period is setting physicians up for failure.

Because we do not have data that describes reporting challenges for the 2017 MIPS performance year, TMA referred to the 2016 Physician Quality Reporting System (QPRS) experience report published by CMS in August 2018 to inform our comments. In the report, CMS states that claims reporting continued to be the most popular reporting mechanism and that the main challenges to satisfactory reporting for the claims submission mechanism included: 1) failure to identify eligible patients or claims, 2) QDC submission errors, and 3) failure to submit QDCs for at least 50 percent of eligible instances.

Recognizing these challenges, TMA reiterates that educating physicians about the claims submission process via guides late in the performance period is much too late and not fair to physicians who are trying in good faith to meet all data requirements. For this reason, in expanding this option to all group sizes, TMA strongly urges CMS to do more to address the known challenges and publish educational materials before the start of each performance period.

We believe this would help physicians, practice staff, and/or billing vendors understand this submission process and avoid the pitfalls to quality reporting via Medicare Part B claims.

TMA Recommendation: In support of physician choice in selecting the data submission mechanism best suited for their practice, TMA recommends the Medicare Part B claims reporting option be made available to all groups, regardless of practice size. To foster successful submission of data on quality measures, CMS should prioritize physician education and publish fact sheets and guides for the claims submission mechanism before each performance year rather than late in the performance year.

Submission Deadlines

CMS proposes consolidating the submission deadlines for all data submission mechanisms and performance categories into one deadline – except for the claims submission mechanism. The agency also proposes extending the deadline to the next business day when the date falls on a weekend or holiday, and extending the deadline when unforeseen technical issues occur within the QPP portal to account for lost time. TMA believes having only one deadline would help simplify the MIPS program and fully supports this policy proposal.

However, the same deadline also should apply to the claims submission mechanism. For the 2017 MIPS performance year, we remind CMS that the submission deadline published in all the materials sent via its communications channels and publications only stated March 31. It was not until Feb. 9, 2018, that the agency clarified through email that the deadline for the claims submission mechanism was actually March 1. For this reason, if the agency does not use the same deadline for claims, we urge CMS to make it clear to physicians by emphasizing the different deadlines at the start of the performance year rather than three weeks before the deadline.

TMA Recommendation: To simplify the data submission process, CMS should consolidate the deadlines for all data submission mechanisms and performance categories into one single deadline.

Submission Criteria for Reporting Quality Measures, Excluding CMS Web Interface Measures and the CAHPS for MIPS Survey Measure

CMS requires physicians to submit data on at least six measures including at least one outcome measure. If an applicable outcome measure is not available, physicians must report one other high priority measure. If fewer than six measures apply, physicians must report on each measure that is applicable. For the 2019 performance period, the agency proposes to revise data submission requirements to indicate that physicians who report on a specialty or subspecialty measure set must submit data on at least six measures within that set, provided the set contains at least six measures. If the set contains fewer than six measures or if fewer than six measures apply to the MIPS-eligible clinician or group, they would report on each measure that is applicable. TMA appreciates this clarifying language and supports the proposed revisions but we oppose the six-measure requirement and mandate that physicians must report at least one outcome or high-priority measure as described in our next comment.

TMA Recommendation: To enhance clarity, CMS should revise its data submission criteria pertaining to specialty and subspecialty measure sets.

Data Submission Criteria for the Quality Performance Category

When considering the agency's plans to remove a potentially large number of measures over the next few years while very few new measures are under development, TMA continues to be concerned that some physicians and groups do not have a sufficient number of quality measures to meet the six-measure requirement.

For example, due to measure gaps and through no fault of their own, some physicians and groups have a limited number of applicable measures and measure types for their preferred data submission mechanism and do not have the same opportunity to report on six measures and/or additional outcome or high-priority measures for bonus points. Also, although cross-cutting measures are included in measure sets to offset the limited number measures by specialty, physicians report that cross-cutting measures are the least meaningful to report.

TMA reiterates that the lack of an adequate number of measures and measure types across all data submission mechanisms is a major flaw of the QPP. Many physicians view the existing measures as failing to capture accurately the quality of their practice and specialty as a whole. Without a sufficient number of meaningful and applicable measures for all physicians, we believe many physicians will not engage meaningfully in MIPS to improve individual patient and population health outcomes among their Medicare beneficiaries as MACRA intended.

In addition, for the 2019 MIPS performance year, the agency proposes to allow physicians and groups to submit data on quality measures using more than one data submission mechanism. However, we do not believe that this proposal should be viewed as a solution to our concerns. Although that particular policy offers more flexibility, it would increase administrative and cost burdens associated with the quality category but not solve the problem of insufficient meaningful and applicable measures for all physicians.

To illustrate our ongoing concerns with MIPS measures, TMA offers the following list of facts and issues that affect the quality category. These result in: 1) an inequitable assessment of quality performance due to a lack of parity among measures and measure types for all physicians and across all data submission mechanisms, and 2) inequitable incentive payments based on a poor quality measures portfolio.

- Although provisions in MACRA direct the Secretary to *emphasize* outcome measures under the quality category, TMA notes that the law does not *require* physicians to report data on outcome measures. Because CMS has chosen to make outcome measures a requirement even despite the limited number of outcome measures available (with the majority reportable only through registry), we believe this policy is unfair and complicates the data submission criteria for many physicians.
- On Oct. 30, 2017, CMS launched the Meaningful Measures initiative to streamline quality measures, reduce regulatory burden, and promote innovation. However, the

current proposed rule does not include any significant policy proposal for the 2019 MIPS quality category that would reflect the agency has been effective in meeting the initiative's aims.

- For 2018, the program has approximately 275 MIPS quality measures. Although this number may appear sufficient, the list of measures decreases significantly to just a few when narrowed by data submission mechanism, specialty area, applicable measure per physician, and measure type. Among the 275 MIPS quality measures, very few are reportable through claims or EHR in comparison to the registry reporting mechanism. This disparity steers and encourages physician dependency on costly registry, QCDR, and/or health IT vendors.
- The list of QCDR measures is different from the list of MIPS quality measures. Although there are multiple QCDR measures, the list of measures decreases significantly when narrowed by QCDR vendor, specialty area, and applicable measure per physician. In addition, the use of QCDRs is limited to physicians who choose to contract with QCDR vendors. Many QCDRs require time-consuming data entry processes or costly services to connect to physicians' CEHRT and charge exorbitant fees for MIPS reporting annually.
- Among the list of 275 MIPS quality measures, 186 are process measures and CMS reports that 102 of them are not considered high priority. The agency also reports it plans to incrementally remove non-high priority process measures beginning next year as the new focus is on outcome measures.
- For the 2019 MIPS performance year, CMS proposes to remove 34 measures from the list of MIPS quality measures but proposes to add only 10 new ones.
- Per the CMS Quality Measure Development Plan 2018 Annual Report published by the agency in May 2018, only 19 new measures were at different stages of the measure development process in calendar 2017 for future use in the MIPS program.
- For the 2019 MIPS performance year, with the exception of the CMS web interface and CAHPS survey that use different measures and data completion criteria, the agency will continue to require that physicians and groups submit data on at least six measures including at least one outcome measure. If an applicable outcome measure is not available, physicians must report one other high priority measure. If fewer than six measures apply, physicians must report on each measure that is applicable regardless of whether physicians find the measures meaningful.
- For the 2019 MIPS performance year, the agency will continue to offer bonus points to those who report on additional outcome or high priority measures and engage in end-to-end electronic reporting of quality data. Unless the agency publishes MIPS data that states otherwise, we believe this will adversely affect many physicians as our assessment shows that certain specialties and subspecialties do not have the same opportunity to achieve bonus points due to a limited number of quality measures by data submission mechanism.
- Per the 2016 PQRS experience report published by CMS in August 2018, since the inception of the PQRS program in 2007, the Medicare Part B claims data submission mechanism continues to be the most utilized reporting method for quality reporting and is the method that most solo physicians and small practices prefer.
- In the current proposed rule, CMS states it wants to move away from claims reporting since approximately 69 percent of the 73 Medicare Part B claims measures are "topped out." The agency further states it is prioritizing measure development to those that are

reportable via electronic methods and not through claims submission. TMA believes these proposed changes will adversely affect solo physicians and small practices the most as the maximum point potential for the majority of claims measures will soon decrease from 10 to 7 points due to their topped out status before they are removed in their fourth year or sooner.

- Eliminating claims reporting will require that solo physicians and small practices pay additional fees to submit their data on quality measures through registry, QCDR, EHR, or health IT vendors. This would require spending additional time coordinating data collection and reporting via new methods and compounding high practice costs for physicians who also may have to pay additional fees (depending on contract/vendor) to upgrade to the 2015 edition of CEHRT for the MIPS PI category as proposed by CMS for the 2019 MIPS performance year.
- In June 2018, CMS reported that 91 percent of eligible clinicians participated in the 2017 MIPS program, but to date the agency has released no specific data that demonstrates that the majority of physicians successfully met the six-measure requirement for the MIPS quality category.

Therefore, TMA recommends decreasing the number of measures physicians must report for the quality category. To inform our comments in recommending the right number of measures, TMA seeks data that show how many physicians by practice size, specialty area, and data submission mechanism were able to meet full data requirements for six quality measures in 2017, including outcome and high-priority measures and additional measures for bonus points. Until such data are published, we do not believe the agency should continue to require six measures for the MIPS quality category nor require that physicians report on at least one outcome or high-priority measure. Instead, we urge CMS to support physician choice and require data only for the measures physicians find meaningful to their patients, practice, and specialty. To improve fairness, we further urge the agency to reevaluate and change its scoring policies for the affected physicians who do not have sufficient measures to earn bonus points for the MIPS quality category.

TMA Recommendations: Due to a poor quality measures portfolio that lacks a sufficient number of meaningful measures and measures types for all physicians and data submission mechanisms, TMA urges CMS to reduce the number of measures physicians must report and eliminate the requirement for at least one outcome or high-priority measure. TMA further urges the agency to reevaluate and change its scoring policies for the affected physicians who do not have sufficient measures to earn bonus points for the MIPS quality category.

Expanding the CMS Web Interface Measures to Groups with 16-24 Clinicians

CMS seeks comment on expanding that mechanism to groups with 16-24 eligible clinicians from the current requirement of 25 or more eligible clinicians. The agency states that preliminary analysis has indicated that groups with this practice size may not be able to meet case minimum thresholds on multiple CMS web interface measures and further states it can possibly mitigate this issue if it requires groups to report on only a subset of measures, such as the preventive care measures.

Per the agency's 2016 PQRS experience report, TMA notes that challenges continue for those who submit data through the CMS web interface. These include a lack of understanding about the assignment and/or sampling methodology, inexperience using the web interface, and challenges with the layers between those providing care and those abstracting the data for submission, which resulted in some users not inputting the data properly.

In general, although we support policies that provide for voluntary participation in using a particular data submission mechanism, we recommend that CMS not expand this option to groups with 16-24 eligible clinicians until the agency has evaluated all advantages and disadvantages for these smaller groups and shared such data through comment and rulemaking. TMA further recommends the agency prioritize the development of educational materials that address the known challenges for groups who submit data through the CMS web interface.

TMA Recommendation: The agency should not expand the CMS web interface option to groups with 16-24 eligible clinicians for the 2019 MIPS performance period. TMA further recommends the agency quickly develop educational materials that address the known challenges for groups who submit data through the CMS web interface.

Submission Criteria for Groups Electing to Report CAHPS for MIPS Survey

The CAHPS for MIPS survey measures patient experience and care within a group. CMS states the survey is not applicable to groups that do not provide primary care services, such as a group of surgeons or other specialties. Currently, the survey contains ten summary survey measures that include a total of 54 questions in yes or no and multiple-choice format to assess the following:

1. Getting Timely Care, Appointments, and Information
2. How Well Providers Communicate
3. Patient's Rating of Provider
4. Access to Specialists
5. Health Promotion and Education
6. Shared Decision Making
7. Health Status and Functional Status
8. Courteous and Helpful Office Staff
9. Care Coordination
10. Stewardship of Patient Resources

The CAHPS for MIPS survey collects patient experience data from Medicare Part B patients only and survey scores are made available for public reporting on Physician Compare. The survey is optional for the MIPS quality performance category for groups with two or more clinicians and virtual groups.

For the 2019 performance year, CMS does not propose any new or revised data submission criteria for groups or virtual groups electing to report the CAHPS for MIPS survey. TMA appreciates that the survey will continue to remain optional. Given that the current CAHPS for MIPS survey as currently designed is not applicable to all physicians and cannot be customized according to specialty or physician preference, and because we support physician choice in selecting only the activities they find meaningful to their practices, TMA continues to

recommend that the survey remain strictly voluntary not only for the 2019 MIPS performance year but for future years of the program as well.

TMA Recommendation: CMS should keep the CAHPS for MIPS survey voluntary for the 2019 MIPS performance year and future years of the program.

Transparency about CAHPS for MIPS Survey Cost Burdens and Scoring

While CMS does not propose any new or revised reporting, recordkeeping, or third-party disclosure requirements related to the CAHPS for MIPS survey, it does propose changes to how the agency scores the survey and how it will treat physicians who do not meet minimum beneficiary sampling requirements. Currently, this survey is available to groups with two or more clinicians, and is not an option for individual clinicians. The survey counts for one of the six measures required for the quality category, as a patient experience measure, and fulfills the requirement to report at least one high priority measure in the absence of an applicable outcome measure. Separate from the quality category, the survey qualifies as one high-weighted activity for the MIPS improvement activities category.

Groups who elect this data submission mechanism must select an additional mechanism (registry, QCDR, EHR/health IT vendor, or CMS web interface) to meet the data submission criteria for the quality category. Groups who choose to conduct the survey must register annually with CMS between April 1 to July 2 prior to the performance year and contract with a CMS-approved survey vendor to collect and report survey data by the MIPS data submission deadline. Groups are then responsible for notifying CMS of which vendor they will use to administer the survey on their behalf and for vendor costs to collect and report survey data to agency.

In the proposed rule, CMS reports vendor costs for the survey range from approximately \$4,000 to \$7,000 depending on services requested. According to the agency's MIPS 2017 Performance Feedback User Guide, the agency reports that even if groups administer the survey and submit six or more quality measures via registry, QCDR, or EHR/health IT vendor, *the survey may not contribute to their quality category score* if it is not one of the top six highest scored measures. However, we note that these cost burdens and scoring considerations are not noted in any of the survey's fact sheets and guides for the 2018 MIPS performance year. TMA believes the omission of this information is misleading to groups and should be included in the agency's CAHPS for MIPS publications and educational materials.

TMA Recommendation: TMA urges the agency to be transparent and inform physicians of the cost and scoring considerations for the CAHPS for MIPS survey. The agency should include this information within its document that lists all CMS-approved survey vendors and in all of its related educational materials this year and for futures years of the MIPS program.

Additional Policies for the CAHPS for MIPS Measure Score

After groups register for the CAHPS for MIPS survey, the agency uses a two-step methodology to assign a number of beneficiaries according to each group's practice size (2-24, 25-99, 100 or

more clinicians). The agency assigns Medicare fee-for-service beneficiaries to a group and then randomly samples from those assigned beneficiaries to create the sample for the survey. The survey is administered by vendors from October to January using a CMS pre-notification letter, two survey mailings, and up to six follow-up attempts to complete the survey by phone with beneficiaries who do not return survey by mail.

However, the agency reports that some groups who elect and register for the survey are unable to participate because they do not meet the minimum beneficiary sampling requirements, which is necessary to ensure an adequate number of survey responses. When this happens, and because of the timeframe in which CMS conducts its beneficiary assignment process, CMS is not able to inform groups until “late in the performance year” that the group is unable to have its performance assessed using data from the survey. Therefore, the group cannot have the survey count as one of the measures to meet the six-measure requirement, as a patient experience measure, fulfill the requirement to report at least one high priority measure in the absence of an applicable outcome measure, nor count as a high-weighted activity for the MIPS improvement activities category.

For groups who experience this issue for the first time, CMS proposes a new scoring policy that would allow the agency to reduce the total available measure achievement points for the quality category by 10 points. Because the survey may count as one of the six required measures for the quality category, this action would prevent groups from receiving a score of zero for one of the measures, and would remove any need for groups to find another measure late in the performance year. The agency further proposes to withdraw this new scoring policy for groups who register for the survey for a consecutive performance period and are unable to meet the sampling requirements again. This implies the agency would assign a score of zero for the survey at the time of the second occurrence, but does not provide a rationale why it would do so.

Because the scoring policy would affect both the MIPS quality and improvement activities categories, TMA does not support these policies as proposed. Given that vendors begin the survey process in October, we seek clarification on the exact time period CMS will notify groups that they did not meet the minimum beneficiary sampling requirements. We also seek clarification whether CMS would *automatically* apply the scoring policy and reduce the group’s achievement points by 10 points for each category or first provide groups with the option to report on an alternate quality measure and improvement activity if it so chooses. We further seek clarification as to what kind of physician protections the agency will institute as part of its CMS-approved vendor policies pertaining to groups who must cancel their contracts with survey vendors “late in the performance year” when they receive word from the agency. For example, will groups still have to pay vendor fees or will the agency make it policy that vendors cannot charge fees to groups who notify them late in the performance year that they do not meet the minimum beneficiary sampling requirements?

TMA reminds CMS that in the 2018 QPP proposed and final rule, it was the agency’s idea and decision to move the survey window to an earlier timeframe because the previous time period was operationally problematic for the agency to compute scoring in a timely manner. Instead of November through February, vendors now administer the survey between October and January. To be clear, we believe the agency created this situation, not physicians. Because this issue is out

of physician control, TMA recommends that groups not be held accountable for vendor costs when they were at the mercy of the agency's administrative procedures that resulted in a last-minute cancellation with the survey vendor.

TMA Recommendation: TMA urges CMS not to hold groups accountable for vendor costs that result from the agency's late notification process about whether they met the minimum beneficiary sampling requirements to administer the CAHPS for MIPS survey.

Minimum Beneficiary Sampling Requirements for the CAHPS for MIPS Survey

CMS states that it does not want groups to register for the CAHPS for MIPS survey if they know in advance that they are unlikely to meet the minimum beneficiary sampling requirement for the survey. The agency seeks comment on whether the agency should limit its proposed new policy, which would prevent no to low scores for the quality and improvement activities category, to a group's initial occurrence rather than applying it again to a group's second occurrence (e.g. two consecutive performance periods.)

Upon review of the survey's two-step attribution methodology for the beneficiary assignment process, and given that physicians do not have access to Medicare's claims system, Parts A and B enrollment data, data to determine plurality of services, and other pertinent data, we believe it would be impossible for any group to definitively know whether it would meet the minimum beneficiary sampling requirements.

TMA seeks clarification as to what type of information CMS provides to groups when they first fail to meet requirements that would demonstrate that they should "know in advance that they are unlikely to be able to meet the sampling requirement" a second time. For example, what types of data should groups be using to estimate the number of beneficiaries annually? How does CMS expect groups to know where they will stand for two consecutive performance periods? What if the group experiences changes among its medical staff that would impact the group's number of beneficiaries? When it comes to the CAHPS for MIPS survey, what type of assistance does CMS offer to groups who in good faith are trying to meet compliance, engage meaningfully in the program, and meet all data requirements?

Rather than create a punitive policy for the second occurrence, and for the purposes of preventing no to low scores for the MIPS quality and improvement activities category, TMA recommends CMS instead provide groups with the information that would help them determine the best course of action to take for the consecutive performance period and future years of the MIPS program.

TMA Recommendation: TMA urges CMS to carefully reconsider its proposed CAHPS for MIPS survey scoring policies. Rather than create a punitive policy for the second occurrence of not meeting minimum beneficiary sampling requirements, TMA recommends the agency instead create a helpful policy that would help them determine the best course of action to take for the consecutive performance period and future years of the MIPS program.

Topped Out Measures

In the 2018 QPP final rule, CMS finalized a four-year timeline to identify topped out measures, after which the agency may propose to remove the measures through future rulemaking. After a measure has been identified as topped out for three consecutive years through the benchmarks, the agency may propose to remove it through rulemaking. Therefore, in the fourth year, if finalized through rulemaking, the measure would be removed and would no longer be available for reporting. CMS seeks comments on whether measures that reach an “extremely” topped out status (such as with an average mean performance of 98-100) should be removed the following year rather than phasing them out using the four-year timeline.

TMA disagrees that measures should be removed immediately the following performance year. Rather than base a topped out measure’s removal solely on the mean performance rate, we recommend CMS take additional factors into consideration, such as reporting rate across all specialties, case mix, practice size, location, and demographic and socioeconomic variables, and share such data through rulemaking before removing such measures. In addition, TMA reiterates our opposition to decreased scoring for topped out measures for physicians and groups who already may encounter a limited number of applicable measures.

TMA Recommendation: To prevent measures from being removed prematurely from the list of MIPS quality measures, CMS should not immediately remove “extremely” topped out measures based solely on performance rate without taking into consideration additional factors.

Categorizing Measures by Value

CMS seeks comment on implementing a system where measures are classified as being of a particular value, such as gold, silver, or bronze, and points are awarded based on the value of the measure. For example, the agency states that measures that are considered “gold” standard could include outcome measures, composite measures, or measures that address agency priorities. The CAHPS for MIPS survey, which collects patient experience data, may also be considered a high value measure. Measures that are considered second tier, or at a “silver” standard, would be those that are considered process measures or topped out outcome measures. Lower value measures, such as standard of care process measures or topped out process measures, would be considered “bronze” measures.

TMA acknowledges that all quality measures may have different value to different physicians. However, we note that CMS already uses many descriptors to describe and categorize quality measures. For example, current quality measures are categorized by measure title; National Quality Forum number; MIPS identification (ID) number; CMS electronic ID number; measure description; data submission method; measure type designation (efficiency, intermediate outcome, outcome, patient engagement/experience, process, and structure measures); National Quality Strategy Domain designation (patient safety, person-and caregiver centered experience and outcomes, communication and care coordination, effective clinical care, community/population health, and efficiency and cost reduction); specialty area and specialty measure sets; primary measure steward; and by program such as MIPS, ACO, and Million

Hearts. In addition, TMA notes that the agency states it will further categorize quality measures by 19 new meaningful measures areas and six overarching quality priorities identified by its Meaningful Measures initiative.

Due to the program complexity that already exists in MIPS and because CMS already uses so many descriptors and categorizations for each quality measure, TMA opposes introducing a new classification system that would further categorize measures as gold, silver, or bronze, and any new scoring policy that would assign points based on a measure's value as determined by the agency. In many instances, we believe measures CMS may consider to have low value actually may have high value and be very meaningful for some physicians and groups. Therefore, they should not receive lower scores for selecting measures they find meaningful to their practice, specialty, and patients.

TMA Recommendation: To minimize program complexity, CMS should not introduce a new classification system to categorize measures as gold, silver, or bronze. To foster program fairness, CMS should not create new scoring policies that would assign points based on a measure's value that may differ from the value placed on a measure by physicians and groups.

All-Payer Data Requirement for the Quality Performance Category

For the MIPS quality category, the agency does not propose to change data requirements for the 2019 performance year. This means the agency will continue to require clinical data for patients across all-payers from physicians who submit data through a qualified registry, QCDR, and health IT/EHR vendor, but only require Medicare Part B data from physicians who submit data through claims submissions, CMS web interface, and the CAHPS for MIPS survey.

TMA continues to oppose the agency's requirement and use of all-payer data to assess physicians' performance on quality measures and determine Medicare Part B payment bonuses and penalties. Quality performance and Medicare Part B payment bonuses and penalties should not be based on clinical data representing non-Medicare beneficiaries.

MACRA specifically states that "analysis of the performance category described in paragraph (2)(A)(i) *may include* data submitted by MIPS eligible professionals with respect to items and services furnished to individuals who are not individuals entitled to benefits under part A or enrolled under part B." (Emphasis added.) Since the law is permissive on this subject, all-payer data should not be required of physicians and groups for several reasons.

We reiterate that Medicare and other payers are very different in their patient populations; medical policies; billing requirements; payment for services, procedures, and preventative care; and care coordination efforts. The payers also may have different patient education and outreach programs. These differences can result in varied patient choices, experiences, and quality outcomes that will, in many instances, favor practices with commercially insured patients over those who have a high volume of Medicare or Medicaid beneficiaries or serve a diverse or disadvantaged population.

Given that individual patient and population health outcomes may vary by payer type and payer mix may vary among practices, TMA believes that this policy results in an inequitable assessment of quality performance among physicians and practices. Furthermore, the data needed for appropriate risk adjustment will not be available for patients who are not Medicare beneficiaries. We feel strongly that physicians and groups should not be rewarded or penalized based on variations in payer mix and patient populations.

In addition, the agency requires that data contain a minimum of one quality measure for at least one Medicare patient when reporting through data submission mechanisms that require all-payer data, thereby potentially basing Medicare Part B payment adjustments on patient care largely representing other patient populations and not Medicare beneficiaries. TMA believes that a Medicare physician payment system that requires some physicians to report a portion of the data to represent all-payers and other physicians to report only Medicare Part B data, coupled with the fact that quality benchmarks are based solely on Medicare data, is a flawed program policy.

Furthermore, we believe this requirement will contribute to undue administrative burden by increasing significantly the documentation and volume of data physicians must report per measure and make it more difficult to meet the threshold requirements for each data submission mechanism. TMA believes requiring all-payer data and expecting such a large quantity of patient data to be submitted successfully and without errors is unrealistic and will not be feasible for many physicians, especially for those entering data manually through registries and QCDRs.

Lastly, TMA notes that many of the MIPS policies are designed to avoid selection bias that result in cherry picking and manipulating data to game the system. Yet the agency is promoting this very opportunity through this policy as it previously acknowledged that it does not have the capability to validate data completeness for all-payer data and instead will rely on physicians, groups and vendors to simply certify to the best of their knowledge that the data submitted to CMS is true, accurate, and complete.

TMA Recommendation: To support a fair program and equitable incentives, CMS should eliminate the requirement for all-payer data for assessing physician performance on quality measures and determining Medicare Part B payment bonuses and penalties.

Floor for Scoring Quality Measures and Measures That Do Not Meet Case Minimum, Data Completeness, and Benchmarks Requirements

For the 2019 MIPS performance period, CMS proposes again to apply a three-point floor for each measure that can be reliably scored against a benchmark based on the baseline period. Measures submitted that meet data completeness but do not have a benchmark and at least 20 cases will continue to receive three points per measure. Measures submitted that do not meet data completeness criteria, regardless of whether they have a benchmark or meet the case minimum, will continue to default to one to three points depending on practice size.

For the 2020 MIPS performance period, the agency proposes to assign zero points for measures that do not meet data completeness for groups with more than 15 clinicians, but states that measures submitted by small practices with 15 or fewer clinicians would continue to receive

three points for all future MIPS performance periods, although the agency may revisit this policy through future rulemaking.

TMA appreciates the efforts made by the agency to create favorable scoring for small practices. However, TMA opposes the policy proposal that would assign zero points in 2020 for measures that do not meet data completeness criteria. Because we feel granting partial credit offers some reward for physicians and groups that undertake costly reporting efforts, TMA strongly urges CMS to maintain quality scoring that ensures credit is granted to practices of any size that attempt to report the required data. We believe this policy is necessary to create some incentive to report. Therefore, rather than apply a punitive all-or-nothing approach to scoring quality measures for larger groups, TMA recommends CMS maintain the three-point floor for all physicians and groups regardless of practice size

TMA Recommendation: To support program consistency and fair scoring, CMS should maintain the minimum three-point floor for all physicians and groups regardless of practice size, including for those who do not meet data completeness criteria.

Quality Reporting Threshold for Data Completeness Criteria

In the 2018 QPP final rule, CMS finalized a 60-percent quality reporting threshold as part of its data completeness criteria for physicians reporting data on quality measures via registry, QCDR, EHR, and claims for the 2018 and 2019 performance years. Because the agency uses sampling protocols for the CMS web interface and CAHPS for MIPS survey, the 60-percent reporting threshold does not apply to those mechanisms.

Per CMS, 2019 quality reporting thresholds for data completeness include:

- Medicare Part B claims measures: *60 percent* of individual MIPS eligible clinician's, or group's (beginning with the 2021 MIPS payment year) Medicare Part B patients for the performance period,
- Registry, QCDRs, EHR measures: *60 percent* of individual MIPS eligible clinician's, or group's patients across all payers for the performance period,
- CMS web interface measures: Sampling requirements for the group's Medicare Part B patients: Populate data fields for the first 248 consecutively ranked and assigned Medicare beneficiaries in the order in which they appear in the group's sample for each module or measure. If the pool of eligible assigned beneficiaries is fewer than 248, then the group would report on 100 percent of assigned beneficiaries, and
- CAHPS for MIPS survey: Sampling requirements for the group's Medicare Part B patients.

The agency continues to state it believes it is important to incorporate higher data completeness thresholds to ensure a more accurate assessment of performance on quality measures and to avoid any selection bias. While we acknowledge this rationale, we disagree that increasing the reporting threshold by 10 percent would ensure a more accurate assessment and deter selection bias. Furthermore, this rationale contradicts the agency's policy on all-payer data. We remind CMS that it promotes the opportunity for selection bias and cherry picking through its policy on requiring all-payer data for this category as the agency previously acknowledged that it does not

have the optimal capability to validate data completeness for data representing non-Medicare beneficiaries from all payers. In addition, we note that among the all-payer data submitted through registries, QCDRs, and EHRs, the agency requires a minimum of one quality measure for at least one Medicare patient to meet the 60-percent reporting threshold for data completeness. Yet, CMS requires a full 60 percent of Medicare Part B patients for those reporting through claims, which we assume can be validated through the agency's claim system.

Because an increase in the threshold can result in failed reporting and lower quality scores for physicians, TMA continues to oppose the 60-percent quality reporting threshold and requests the agency return the threshold to 50 percent until the agency has MIPS data insights similar to the data found in CMS PQRS experience reports. The agency's recently published 2016 PQRS experience report showed that failure to meet the 50-percent threshold was among the three main challenges to quality reporting for the most utilized reporting mechanism – through Medicare Part B claims.

TMA recommends that CMS postpone further increasing the threshold until it publishes the 2017 MIPS experience report that provides program results and evidence so physicians and stakeholders can evaluate the data to make an informed decision and recommendation. This information would help inform the agency, physicians, and other relevant stakeholders in determining the right threshold increase at the right time.

TMA Recommendation: To promote fair scoring and ensure physicians and groups are able to achieve the reporting threshold for data completeness, CMS should return the quality reporting threshold to 50 percent for 2019 and retroactively apply that change to the 2018 performance year. The agency should postpone further increases in the reporting threshold until it publishes data insights and evidence that an increase would not adversely affect physicians.

Scoring Flexibility for Measures with Clinical Guideline Changes During the Performance Period

CMS states that as clinical evidence and guidelines change, approved quality measures used in MIPS may no longer reflect the most up-to-date clinical evidence, could result in patient harm, and/or otherwise provide misleading results as to good quality care. To address this issue, the agency proposes to provide scoring flexibility for quality measures that have clinical guideline changes or other changes to evidence supporting the measure that occur during the performance period. The scoring flexibility would involve suppressing such measures without rulemaking and reducing the total available measure achievement points for the quality performance category by 10 points for physicians who submit a quality measure significantly impacted by these changes.

TMA does not support this policy as proposed and seeks clarification as to what criteria the agency will use to define "significantly impacted measures." For purposes of scoring flexibility for affected measures, TMA recommends that the agency consider the time period and duration for which the measure was valid before excluding the measure from the calculation of the quality category. For example, TMA recommends that CMS calculate a score even if the data spans a shorter performance period but meets the case minimum, reporting threshold for the given time

period, and can be reliably scored against a benchmark. Compare that score to what the score would have been if the measure had been suppressed and removed from the calculation and achievement points were reduced by 10 points, and then take the higher of the two scores for the quality category. If the measure is scored, and for the purposes of transparency, make a notation on Physician Compare about the changes to clinical guidelines and duration for which the measure was valid so that the data provided is not misleading to the public.

In addition, TMA is concerned that the agency states it will publish on its website a list of suppressed measures only whenever technically feasible, but not later than the beginning of the data submission period. Because changes in clinical evidence and guidelines could result in patient harm, we believe CMS should prioritize notifying physicians upon the time the agency is notified of such changes by the measure stewards. In addition to publishing a list on the website, TMA recommends the agency immediately alert physicians through the QPP email listserv and portal or other appropriate means of communication. The alert should include information about 1) what clinical evidence and guidelines have changed that have resulted in the measure being designated as a “significantly impacted measure,” 2) how the changes may result in patient harm, 3) how these changes affect physicians’ scores so that they may consider reporting on a different measure if they prefer, and 4) how to contact the measure steward for additional information. CMS also should ensure that this information be disseminated immediately to all registries, QCDRs, EHR, health IT vendors, CMS web interface participants, and Medicare Administrative Contractors (for those reporting via claims) so that they too can alert and inform physicians about significantly impacted measures.

TMA Recommendations: CMS should consider the time period in which changes to clinical evidence and guidelines occurred before excluding the measure from the quality category calculation. To prevent patient harm, CMS should prioritize and create a process that immediately alerts physicians and third-party intermediaries about quality measures that have changes to clinical evidence and guidelines.

Cost Performance Category

CMS states measuring cost is an integral part of measuring value and that it recognizes that cost measures are still early in development and clinicians are not as familiar with them as quality measures. The agency proposes adding eight episode-based measures to the cost performance category in addition to the existing per-capita cost and Medicare-spending-per-beneficiary measures. Of these new measures five of them are surgical and three of them are inpatient hospital based.

While we agree that measuring cost is an integral part of value measurement, it is useful as a comparison tool only if the underlying component parts are fair and meaningful. The per-capita cost and Medicare-spending-per-beneficiary measures may be useful for some purposes, but they are misleading and harmful as measures of physician performance. The attribution rules used in calculating these measures can and do cause physicians to be rated based on costs of services that are completely unrelated to any medical care the physician provided, ordered, or recommended. Using these measures, physicians are often being held accountable for services about which they had no knowledge, that were incurred in entirely different localities, that are completely

unrelated to the services that they provided to the patient, or even possibly for services that they specifically advised against.

We applaud CMS for developing cost measures that are based on episodes of care that are within the control of physicians and look forward to more such measure in upcoming years. As with any new measure, we expect CMS will evaluate them to determine if they need risk adjustment and then appropriately apply such adjustment. Additionally, these measures must be evaluated to determine whether physicians treating disadvantaged populations are treated fairly; if not, they must be adjusted appropriately.

TMA recognizes that the Bipartisan Budget Act of 2018 requires MIPS to allocate at least 10 percent of the final score to the cost category. Nonetheless, without adequate adjustments to eliminate the known effects of various socioeconomic and cultural factors, this category will always penalize physicians serving disadvantaged populations.

TMA Recommendation: CMS should continue to develop episode-based measures for the cost category. As CMS uses these eight newly created measures it must ensure that the measures are evaluated to identify any need for risk adjustments and to see if they measure physicians who treat disadvantaged populations fairly. CMS should measure physicians affected by these episode of care benchmarks solely on these new benchmarks and not the per-capita and Medicare-spending-per beneficiary measures. As CMS creates additional episode of care measures, the per-capita cost and Medicare-spending-per-beneficiary measures should be completely eliminated. CMS should use only measures that are within the physician's control.

Improvement Activities Performance Category

For the third year of the QPP, TMA appreciates the agency's inclusion of a broad range of activities to meet the requirements for the improvement activities category. We reiterate that of all the MIPS requirements, this may be the only one that is completely within physicians' control because they can choose which activities to participate in and complete them using their own time and efforts. We are also very pleased that CMS will continue to allow physicians and groups to report improvement activities through as many submission mechanisms as necessary in a manner that best accommodates their practice, including simple attestation. To avoid program complexity and to keep this category as simple as possible, TMA continues to recommend that CMS make no changes to the improvement activities category other than to amend or add additional activities to the inventory.

TMA Recommendation: To foster program consistency and minimize program complexity, CMS should make no changes to the improvement activities category other than to amend or add additional activities to the inventory.

Submission Criteria

CMS proposes to change terminology that describes the data submission process for reporting on improvement activities. Instead of "via qualified registries, EHR submission mechanisms,

QCDR, CMS web interface, or attestation,” the agency proposes to state that data would be submitted “via direct, login and upload, and login and attest.” TMA reiterates that we strongly oppose changes to the terminology used that describes the current data submission mechanisms and process, and for any other terms currently used in the MIPS program.

TMA Recommendation: To foster program consistency and minimize program complexity and physician confusion with annual terminology changes, CMS should not revise the terms used to describe its data submission process for the improvement activities category.

Proposed New Criteria

CMS states it believes it is important to place attention on public health emergencies, such as the opioid epidemic, when considering improvement activities for inclusion in the inventory, because this raises awareness about the urgency of the situation and promotes best practices to combat those public health emergencies. For this reason, the agency proposes to adopt an additional criterion entitled “Include a public health emergency as determined by the Secretary” to the criteria for nominating new improvement activities beginning next year.

TMA appreciates this proposal, but we do not support this additional criterion as proposed without further clarity. If the agency moves forward with this additional criterion, we recommend that physicians who engage in activities aimed at addressing public health emergencies receive full credit for the activity even if the duration of the public health emergency does not span at least 90 days as required for this category. We also want to make sure any activity determined by the Secretary always remains optional. During a live public health emergency and outside the annual call for improvement activities, we further recommend that CMS establish a process that would provide physicians an opportunity to propose for consideration by the Secretary an activity that would help address that emergency. Activities approved by the Secretary within this context would then be eligible for *immediate implementation* within the current performance period and eligible for MIPS credit for this category rather than waiting for the activity to be approved through the standard nomination process.

TMA Recommendation: For activities aimed at helping to combat public health emergencies, CMS should ensure such activities remain optional and grant full credit for each activity even if the duration does not span at least 90 days as currently required for this category. The agency also should establish a process, outside the annual call for improvement activities, whereby physicians can propose an activity for consideration by the Secretary for immediate implementation during a public health emergency declaration.

Promoting Interoperability Performance Category

TMA appreciates CMS’ desire to reduce burden and increase flexibility, but even more simplicity is needed. Changing the name of a category and associated measures add to the program’s complexity. TMA urges CMS to seek a path of simplification that nudges users toward efficient and interoperable use of EHRs without fear of failure or penalty.

Physicians need well-designed systems that support physician workflows, are interoperable, and can compile needed health information to improve patient safety and lead to improved health outcomes.

The comments below detail areas for improvement. Bottom line, physicians need less time checking computer boxes that do not improve patient care, and more clinical time with the patient. This is true for every single specialty.

Proposed Revisions to the EHR Reporting Period and eCQM Reporting Period in 2021 for EPs Participating in the Medicaid Promoting Interoperability Program

CMS proposes that state Medicaid Promoting Interoperability Programs require data submission no later than Oct. 31, 2021, to accommodate the required payout to Eligible Providers (EPs) by Dec. 31, 2021.

TMA agrees with CMS on the timing of the Medicaid Promoting Interoperability payments to Medicaid Eligible Providers and that it is right to require reporting for any 90-day period provided that the end date falls before Oct. 31, 2021. This will allow payments to be processed and distributed prior to the program end date of Dec. 31, 2021.

TMA Recommendation: Maintain the proposed timing of the Medicaid Promoting Interoperability payments to Medicaid Eligible providers.

Proposed Change to Objective 6 Coordination of Care Through Patient Engagement

CMS is proposing to retain the 5-percent participation requirement for Objective 6, Measures 1 (View, Download, or Transmit) and 2 (Secure Electronic Messaging) rather than raising it to 10 percent as required in the Stage 3 final rule.

TMA agrees with CMS that physicians have difficulty attaining these measures due to patient interest and limitations, especially among the vulnerable Medicaid population. Physicians have no problem encouraging use of technology tools by patients, but not all populations benefit. CMS may consider reducing the requirement to less than 5 percent. If the physician correctly diagnoses and treats a patient's condition, and the prescribed medication is working effectively, the need for follow-up communication diminishes.

TMA Recommendation: CMS should reduce Objective 6 patient engagement measure requirements to 2 percent and continue to monitor the results to ensure that physicians are not unduly burdened with requirements not utilized by patients and beyond the physician's control.

Proposed Change to the Syndromic Surveillance Reporting Measure

CMS proposes expanding Measure 2 (Syndromic Surveillance reporting) of Objective 8 to include EPs practicing in an urgent care setting. CMS further proposes to include any EP defined

by the state or local public health agency as a provider who can submit syndromic surveillance data.

TMA agrees with CMS that public health capabilities and requirements vary greatly from state to state. The proposed change allows EPs to follow state capabilities and requirements.

TMA Recommendation: TMA recommends that CMS require states to appropriately educate participating EPs on exactly what is required for compliance with Measure 2. The bifurcation of state and federal requirements on some measures further complicates compliance and reduces the chances of successful participation.

Promoting Interoperability (PI). Certification Requirements

CMS requires that MIPS eligible clinicians use the 2015 CEHRT beginning in 2019.

TMA agrees that it is time to require the 2015 CEHRT to reduce industry confusion and to provide updated standards and functionality that support interoperability and patient access to information through APIs. TMA further appreciates the 2015 CEHRT capability that requires products to export data from one patient, a set of patients, or a subset of patients. For too long physicians have been held hostage by vendors charging exorbitant fees to export data. TMA remains concerned about interface connection and maintenance fees that electronic health record (EHR) vendors charge to physicians. For many years, TMA has advocated for universal use of extensible markup language (XML) or a similar standard (e.g., FHIR) as a way of exchanging meaningful health data, as is used in accounting and other industries. Universal common encoding of *all* data elements could permit disparate systems to share and consume information much more easily. Information consumed by a receiving EHR could be placed correctly within the system to give it meaning and make it useful. It is important that physicians have the ability to import patient data from one EHR to another, especially when changing vendors. CMS needs to be sure import capabilities are part of the requirement of CEHRT vendors. The EHR vendor community is not aligned when it comes to charging additional fees for major upgrades. Therefore, CMS should maintain a PI exemption for physicians who would face significant hardship when upgrading their EHR from 2014 to 2015 CEHRT.

TMA Recommendation: TMA recommends that CMS and ONC continue to monitor EHR vendor readiness during the 2014 to 2015 CEHRT transition period. TMA urges CMS to provide a MIPS exclusion for physicians unable to comply with 2019 MIPS due to EHR vendor readiness issues. TMA requests clarification as to whether the ability to export data from the CEHRT also implies that the data can be imported into another CEHRT. If not, the ability to import data that has been exported from a different CEHRT should be required.

Proposed Scoring Methodology Beginning with the MIPS Performance Period in 2019

CMS is proposing a new scoring methodology in 2019 in an attempt to make the scoring simpler, more flexible, and less burdensome.

TMA understands CMS' laudable efforts to push technology to better serve the patient by having the right information at the right time to support physician decision making in the care of patients. TMA is concerned that the reduced number of measures could actually make achieving the desired goals more onerous. TMA appreciates the proposed removal of some measures, but worries that fewer options may diminish a physician's ability to succeed with the PI category. For example, the push towards interoperability is still wrought with industry problems beyond the control of physicians and providers. The ability for physicians to comply with supporting electronic referral loops, sending and receiving, is still limited by the lack of industry progress. TMA urges CMS to continue monitoring and pushing for better systems so that physicians can focus more on clinical care and less on technology compliance.

Under the current PI requirements, physicians may earn up to 155 points in the PI category. The proposed methodology requires a physician to score perfectly in all areas to attain 100 points (excepting the 10 bonus points in 2019). Should CMS decide to move forward with the new scoring methodology, CMS should provide more opportunities for physicians to score additional points rather than weighting a few measures.

It seems that CMS is proposing an approach to scoring with less flexibility, as reflected by this statement: "If a MIPS eligible clinician fails to report on a required measure or claim an exclusion for a required measure if applicable, the clinician would receive a total score of zero for the PI performance category." The CMS reporting tool should be built such that the physician either has to report the measure or provide a reason for claiming the exclusion. This is far preferable to pushing a physician to a zero score over one measure. If the physician fails with a measure or if CMS does not approve the exclusion, the physician should not receive a zero score for the PI category. Scoring on other measures should be accepted.

For physicians who are eligible for exclusions on some measures, TMA agrees with the redistribution of the points to other measures and objectives within the PI category.

TMA Recommendation: CMS should allow more flexibility with PI category scoring so that physicians receive credit for measures met versus the punitive all-or-nothing approach. Further, CMS should allow more scoring opportunities within the PI category.

Promoting Interoperability Measure Proposals. Measure Proposals for the e-Prescribing Objective

CMS is proposing adding two new categories within the e-prescribing objective: 1) Query of prescription drug monitoring program (PDMP); and 2) Verify opioid treatment agreement. These new categories are proposed to be optional in 2019 and required in 2020 and beyond.

TMA applauds CMS' commitment to combating the opioid epidemic and making it a priority for the agency. However, much of this work is happening at the state level as the PDMP programs and electronic prescribing of controlled substances (EPCS) capabilities mature. As states oversee the integration of PDMP tools and requirements, the federal government should not interfere by having separate and potentially conflicting requirements. CMS should further understand that the range of controlled substance prescribing among physicians varies greatly; some prescribe them

hourly, while others only once a year. These two new categories do not make sense for all physicians and therefore should not be required.

TMA Recommendation: TMA strongly opposes the addition of the two new e-prescribing measures requiring the query of the PDMP and verification of opioid treatment plan.

Proposed Measure: Query of Prescription Drug Monitoring Program (PDMP)

This new measure is proposed to be optional in 2019 and required in 2020.

TMA opposes inclusion of this new measure as part of the PI category. The PDMP programs are being implemented at the state level with various requirements for checking the PDMP before prescribing a controlled substance. By requiring this new measure, CMS is adding to physicians' administrative burden and creating industry confusion. If CMS does keep this measure, it should provide an exclusion for physicians who may prescribe controlled substances, but simply do not because the patient demographic served does not require schedule II medications.

TMA Recommendation: TMA strongly opposes adding a measure requiring physicians to query the Prescription Drug Monitoring Program (PDMP). If the measure is retained, CMS should allow an additional exclusion for physicians who prescribe controlled substances for 50 or fewer patients.

Proposed Measure: Verify Opioid Treatment Agreement

This new measure is proposed to be optional in 2019 and required in 2020.

TMA agrees with CMS' intent to combat the opioid epidemic, however, the use of an opioid treatment plan is very limited if it applies only to patients who are prescribed a 30-day supply of opioids. Therefore CMS should remove this measure altogether or at the very least keep it as an optional bonus measure beyond 2019. Additionally, physicians should not be held responsible if after a reasonable search, they are unable to determine additional opioid prescriptions from other physicians in the previous six-month period.

CMS additionally sought comment as to how a treatment plan should be incorporated into the CEHRT. CMS should allow flexibility so that physicians can determine the best method for retaining and accessing the treatment agreement as needed. For some specialties, the percentage of the population eligible for a treatment plan will be miniscule and not worth spending additional funds to accommodate specific technical access as may be required by CMS.

TMA Recommendation: TMA strongly recommends that CMS remove this measure. Should CMS choose to keep the measure, the "verify opioid treatment agreement" should be an optional bonus measure for 2019 and beyond. TMA supports the implementation of the latest NCPDP SCRIPT, which includes Cancel RX. Physicians have ongoing problems with community pharmacy systems and processes where the pharmacy does not receive some messages they send, such as the "Cancel Rx" SCRIPT message.

Measure Proposals for the Health Information Exchange Objective

CMS believes it can improve the health information exchange (interoperability) measures and further reduce clinician burden. One modification is to change the name of the measures.

TMA appreciates CMS' determination to improve the health information exchange measures to further reduce burden on physicians. TMA believes that changing the names of programs and associated measures is neither helpful nor necessary. In fact, it is harmful as it creates confusion and adds complexity to the program.

TMA Recommendation: CMS should stop changing titles of programs and measures, which adds to the confusion. Changing "Send a Summary of Care" to "Support Electronic Referral Loops by Sending Health Information" changes nothing for the program participants. It is nonsensical.

Proposed Removal of the Request/Accept Summary of Care Measure

CMS proposes removing the Request/Accept Summary of Care Measure as it has determined the measure is not feasible for machine calculation and the measure specification is burdensome to the workflow of physicians and providers.

TMA agrees, especially since it is burdensome to track and does not serve the purpose intended.

TMA Recommendation: TMA agrees with CMS' proposal to remove the Request/Accept Summary of Care Measure.

Proposed Removal of the Clinical Information Reconciliation Measure

CMS is proposing to remove this measure as it is a burdensome and redundant part of the clinical workflow.

TMA agrees that it is redundant and burdensome. CMS surmises correctly that physicians do reconcile information that is sometimes manual and other times electronic. To impose an electronic process when it is not necessary is unduly burdensome.

TMA Recommendation: TMA agrees with CMS' proposal to remove the Clinical Information Reconciliation Measure.

Proposed New Measure: Support Electronic Referral Loops by Receiving and Incorporating Health Information

CMS is proposing a new measure that combines and replaces two existing measures: 1) Request/Accept Summary of Care and 2) Clinical Information Reconciliation.

TMA agrees with the proposed exclusion for any MIPS-eligible clinician who receives fewer than 100 transitions of care or referrals or has fewer than 100 encounters with patients during the

performance period. Consideration should also be given to clinicians who have more than 100 new encounters during the performance period but do not receive an electronic summary of care record. A physician may be capable of receiving an electronic summary of care record, but that does not mean that the previous physician can or will send it electronically.

TMA agrees that physicians should be able to count this measure in the numerator when, upon completion of review of the patient's information, no update to the record is necessary.

If ONC does require developers to recertify for this additional capability, it should come at no cost to the users. CMS and ONC need to consider the additional burdens on the entire health care system that come with every tweak of the rule. The additional certification will likely come at a cost for developers and certifiers, who will likely pass it on to overburdened and overcharged users.

TMA Recommendation: TMA agrees with CMS' stated exclusion from this measure for physicians who receive fewer than 100 transitions of care during the reporting period. TMA believes that physicians should not have to incur extra cost for upgrades and additional certification requirements by the vendor. Physicians already pay hefty annual licensing and maintenance fees to the CEHRT vendors.

Proposed Removal of the Patient Generated Health Data Measure

CMS is proposing to remove the Patient Generated Health Data measure, which TMA has long requested.

TMA believes that this measure should be removed regardless of which scoring proposal is accepted. CMS should not require patient-generated data be captured through the EHR. Physicians clearly want to get data from patients and already have mechanisms within the EHR to capture information provided by the patient. It is a dangerous precedent to open the system in ways that could compromise patient safety and confidentiality. This measure is overly burdensome to physicians and not necessarily helpful to patients as it causes confusion.

TMA Recommendation: TMA agrees with CMS' proposal to remove the Patient Generated Health Data measure.

Proposed Removal of the Secure Messaging Measure and the View, Download or Transmit Measure

CMS proposes removing the Secure Messaging and the View, Download or Transmit measures; both require patient actions.

For years TMA has argued that these measures are burdensome. Physicians are glad to provide this technology as part of the suite of technology services for patients, but physicians cannot control patient participation, and for some practices, the patient demographic is highly unlikely to engage in this type of technology.

TMA Recommendation: TMA agrees with CMS’ proposal to remove the Secure Messaging and the View, Download or Transmit measures.

Additional MIPS Policies and QPP Components

Small Practice Bonus

CMS proposes to change how the small practice bonus is applied. While the agency believes it is “generally appropriate,” it proposes applying the bonus points to the quality category score and not the composite score. The proposal is to add 3 points to the quality category numerator instead of 5 points to the MIPS final score.

CMS recognized the significant flaws in the MIPS program and created a small practice bonus to help mitigate the significant harm it caused small practice physicians. This harm impacts all sections of the MIPS program not just the quality piece. TMA is extremely disappointed that CMS chose to reduce the small practice bonus but still has not addressed the underlying flaws in the program.

We support the proposal for a small practice bonus and understand that the bonus is a temporary provision designed to offset existing flaws in program measures and reporting. We urge you to continue to improve the validity of program measures through redesign or improved risk adjustment and to continue efforts to simplify program reporting requirements.

However, we adamantly oppose this change to the small practice bonus. This bonus was created to help engage small practices and ensure they were not penalized based on their size. CMS now proposes not only to move the bonus points to a 45-percent weighted category but also to reduce the points from 5 to 3 points for the quality category numerator. This reduction is significant and harmful to small practices. It is short-sighted for CMS to estimate that small practices will have a quality category weighted at 85 percent, not the standard 45 percent. While some practices may experience a category reweighting, this theory cannot be validated without publishing data. Additionally, CMS erroneously assumed that small practices are not at a disadvantage for success in the other categories. This is incorrect. The small practice bonus must be added to the MIPS final score and not a single category.

TMA Recommendation: CMS should not change the small practice bonus point structure or methodology. The small practice bonus should continue to be applied to the MIPS final score.

Complex Patient Bonus

As finalized in the 2018 QPP final rule, CMS will apply a complex patient bonus of up to 5 points to the MIPS final score beginning this year. CMS defines complex patients as those with high medical risk or with dual eligibility. In general, the agency calculates the complex patient bonus by adding the average Hierarchical Condition Category (HCC) risk score to the dual eligible ratio, based on full benefit and partial benefit dual eligible beneficiaries, multiplied by 5, with a 5-point cap.

Per CMS, the complex patient bonus is intended to serve as a short-term strategy to address the impact patient complexity may have on MIPS scoring while the agency continues to work with stakeholders on methods to account for patient risk factors. Although CMS intended to maintain the complex patient bonus as a short-term solution, it does not have sufficient information available at this time to develop a long-term solution. For this reason, the agency proposes to continue the complex patient bonus for the third year of MIPS.

As stated by the agency, studies show that social risk factors, such as being near or below the poverty level, belonging to a racial or ethnic minority group, or living with a disability, can be associated with poor health outcomes. We appreciate the agency's acknowledgement of these studies and support the complex patient bonus until MIPS scoring can account for patient risk factors, including other risk factors and social determinants of health. We continue to advocate that Medicare payments not be affected by quality and cost measures that do not risk adjust for these factors. In addition, TMA urges CMS to educate physicians and groups about the methodology used to determine the complex patient bonus and the determination period used to calculate the average HCC risk scores so they may make improvements to their coding practices in order to actually benefit from this policy.

TMA Recommendation: CMS should continue to apply the complex patient bonus to the MIPS final score.

Virtual Groups

CMS implemented the virtual group option in 2018. MACRA established virtual groups as an alternative MIPS participation option and as a stepping stone to participation in the APM pathway. This option is completely voluntary and provides physicians in solo and small practices (with 10 or fewer clinicians) the ability to band together for the purposes of MIPS participation regardless of specialty and location, and to have the flexibility to determine their own size.

According to the CMS virtual group toolkit published in its 2018 QPP resource library, the agency describes two benefits for this option: 1) Because physicians in solo and small practices may not have enough cases to be reliably measured against a benchmark on their own, they could mitigate this problem by combining their performance volume, and 2) Physicians in solo and small practices who participate in a virtual group could work together, share resources, and potentially increase their overall performance under MIPS.

TMA acknowledges the benefits of the virtual group option, and the fact that this option is intended to help smaller practices. However, we are puzzled as to why CMS has not made outreach and education about this option a priority, especially when it stated in the 2018 QPP final rule that the agency would offer technical assistance only for the first two years of implementation. To date, minimal information about this option has come through the agency's communication channels and QPP website. We urge CMS to do more to educate physicians in solo and small practices about this option. In addition, because the agency has not released any data to inform physicians and stakeholders on the uptake of virtual groups for the 2018 performance year, and because we have heard that very few Texas physicians have engaged in

the option this year, we urge CMS to expand its technical assistance beyond the 2019 performance year.

TMA Recommendation: To help physicians in solo and small practices succeed in MIPS, TMA urges CMS to prioritize and improve its outreach and education about virtual groups. We further urge the agency to expand its technical assistance for virtual groups beyond the first two years.

Virtual Group Registration Process

Rather than using an email registration process, CMS proposes to use a web-based registration system for physicians in solo and small practices who choose to participate in MIPS as a virtual group. The agency believes that this would make the QPP less burdensome for virtual groups and would provide stakeholders with a seamless user experience since the portal is already used for many other facets of the QPP. TMA agrees and supports this proposal as it would simplify the registration process.

TMA Recommendation: To simplify the process, CMS should use the QPP portal as a means to facilitate virtual group registration.

Public Disclosure of Data Error Rates by Third Party Intermediaries (Vendors)

CMS defines a third party intermediary as an entity that has been approved by the agency to submit data on behalf of physicians, groups, or virtual groups for one or more of the quality, improvement activities, or PI categories: a QCDR, qualified registry, health IT/EHR vendor, or CMS-approved survey vendor.

CMS proposes that if a third party intermediary has a data error rate of 3 percent or more, the agency will publicly disclose the entity's data error rate on the CMS website until the data error rate falls below 3 percent.

Recognizing that there are numerous MIPS-related vendors and that data errors continue to be committed by vendors resulting in inaccurate, unusable, or compromised data, TMA is pleased with this proposal. We believe it will help inform physicians about which vendors are best suited for their practices and will drive improvements among the vendor community. However, we recommend publicly disclosing an entity's data error rate starting with any percentage rate rather than waiting for error rates to reach 3 percent.

TMA Recommendation: To inform physicians about the quality of services by MIPS-related vendors, CMS should publicly disclose an entity's data error rate on the CMS website starting with any percentage rate rather than waiting for error rates to reach 3 percent.

Third-Party Intermediaries (Vendors)

CMS proposes to allow physicians and groups to submit their MIPS data through as many data submission mechanisms necessary. TMA believes this new policy will increase utilization of third-party intermediaries (vendors). While the use of multiple submission mechanisms can help maximize scoring, financial burdens associated with data collection and reporting remain. Physicians making a good faith effort to meet all data requirements continue to report data errors committed by vendors. Physicians also report that they are sometimes reimbursed for the fees they paid for reporting through the vendor, but CMS does not remove the payment penalty and does not require that vendors reimburse physicians for payment penalties that stand for an entire calendar year.

For these reasons, TMA continues to urge the agency to institute physician protections and create a hold harmless policy or new hardship exception for physicians and groups who are adversely affected by a MIPS-related vendor's data error. TMA urges CMS not to penalize physicians when vendors fail at any step of the data collection and submission process that affects performance scores or results in a payment penalty, especially when the issue is out of the physician's control.

TMA Recommendation: CMS should create and apply a hold harmless policy or offer a new hardship exception when any MIPS-related vendor commits data collection and submission errors that result in poor performance scores or payment penalties.

Performance Feedback

MACRA requires the agency to provide timely feedback reports to physicians about their MIPS performance. While TMA appreciates the new QPP portal where physicians can access their final scores and performance feedback seven months after the close of the performance period, we do not consider this timely. Of all the MIPS components, we consider timely performance feedback critical to the success of MIPS. Without timely and actionable data to drive improvement, CMS may not see the improvements in individual patient and population health outcomes that MACRA intended.

TMA Recommendation: TMA urges CMS to create a data submission and performance measurement system that provides performance feedback to physicians in real-time, or at least within a timely manner within the performance period, rather than months later.

Targeted Review

TMA appreciates that physicians and groups have the opportunity to appeal data or calculation errors through the targeted review process so they can base their improvement efforts on accurate data. We understand the first targeted review period is in progress and so we provide the agency with some feedback we have received from physicians. We have heard from those who have had difficulty accessing and interpreting their final scores and performance feedback. Some reported problems establishing their portal account while others did not know what their scores meant or what to do to improve their performance moving forward. Due to the complexity of the program and scoring policies, they were not sure if their data was correct and so were uncertain about

whether they should even request a targeted review. We urge CMS to improve its education surrounding performance feedback and the targeted review period.

Additionally, we continue to disagree with the CMS policy that all targeted review decisions made by CMS are final. We urge the agency to improve and expand the targeted review process beyond a one-level process. We further urge CMS to allow physicians to speak with a live person upon request rather than limit them to electronic communication via email. TMA also recommends the agency help physicians and groups understand why they may have low scores so that they may identify areas for improvement and avoid repeating the same errors annually. Lastly, to ensure program transparency, physicians and groups should receive detailed written feedback based on the results of targeted reviews.

TMA Recommendation: To promote program fairness and provide physicians and groups with a sufficient opportunity to appeal inaccurate data or calculation of their MIPS payment adjustments, CMS should expand targeted reviews beyond a one-level process. Further, CMS should include the capability of speaking to a live person upon request and provide detailed written feedback describing the nature of the results of targeted reviews.

Data Validation and Auditing

In the 2017 QPP final rule, CMS finalized policies that would allow the agency to selectively audit physicians and groups on an annual basis. The agency states that those selected would have to comply with Medicare audits as required by law and would be required to:

- Comply with data sharing requests, providing all data as requested by CMS or a designated entity within 45 days, or an alternate timeframe mutually agreed upon by the agency and physician or group; and
- Provide substantive, primary source documents such as copies of claims, medical records for applicable patients, or other resources used in the data calculations for MIPS measures, objectives, and activities. Requests also may include verification of records for Medicare and non-Medicare beneficiaries.

CMS states that it would ultimately recoup incorrect payments from any physician or group that is found to have submitted inaccurate MIPS data. Recognizing these requirements and consequences, we note that as of late August 2018 there has been no official guidance about audit information posted in the QPP resource library other than a table for the improvement activities category that simply lists “suggested documentation”. We remind CMS that for many physicians and groups, the 2018 performance year may be their first year of participation. We believe strongly that physicians and groups should be provided detailed information pertaining to potential future audits; what type of information they should document for every measure, objective, and activity; and how long they must retain records. We urge CMS to publish this information as soon as possible and by the beginning of each performance year thereafter.

TMA Recommendation: We urge CMS to publish detailed information regarding documentation for audits by the beginning of each performance year so that physicians and

groups are well-informed about what type of data will be requested if they are selected for data validation and auditing of MIPS data.

Public Reporting on Physician Compare

We continue to be concerned that the impact of unrelated variables on the measures used in reporting on Physician Compare make the reported information misleading. Although no risk adjustment protocol is ever perfect, the validity of the measures used to compare physician performance could be improved by risk adjustment, which includes factors related to patient educational attainment, race, ethnicity, or religion, and a better factor to measure poverty. Alternatively, accuracy could be improved by implementing stratification or some other measure to compare physicians only to those with comparable patient populations, based on socioeconomic and cultural variables. Furthermore, CMS should factor out the effects of local physician supply, which can affect access to ambulatory care and the use of high-cost emergency room services.

If measures were published on the Physician Compare website in a way that transparently displayed the nature of the measure, we believe that more patients could intuitively understand the data limitations and relevance. Patients realize that physicians often have limited control of patient behavior and choices and that a lower level of patient compliance with recommended treatments or tests may translate into a meaningless measure of the quality of care that physicians provide. The current practice of using ratings instead of reporting the actual measures is not transparent and tends to obscure the actual meaning of the data. Reporting should be completely transparent, including the actual measure value, accurate descriptions of the measure itself, and qualifiers explaining what unrelated factors may affect the data.

TMA Recommendation: CMS should make Physician Compare data more transparent and meaningful.

Proposed Automatic Extreme and Uncontrollable Circumstances Policy Beginning With the 2020 MIPS Payment Year

For the 2017 QPP transition year, CMS issued an interim final rule in which it adopted, on an interim final basis, a policy for automatically reweighting the quality, improvement activities, and advancing care information (now PI) categories for MIPS-eligible physicians affected by extreme and uncontrollable circumstances, such as natural disasters. Beginning with the 2018 performance year, CMS proposes to apply the automatic extreme and uncontrollable circumstances policy it adopted in 2017 to subsequent years of the MIPS program, including the cost category.

TMA expresses its gratitude and thanks CMS again for this policy in 2017. Due to the devastating impact Hurricane Harvey had on Texas physicians and their patients, practices, and communities, we very much appreciate the regulatory relief and flexibility this policy brought to so many physicians. Therefore, we fully support this policy for 2018 and future years of the program.

TMA Recommendation: In support of regulatory relief and flexibilities, CMS should apply the automatic extreme and uncontrollable circumstances policy it adopted in 2017 to subsequent years of the MIPS program, including the cost category.

Improvements for the Automatic Extreme and Uncontrollable Circumstances Policy

Recognizing the importance of this policy, we would like to share our state's experience and offer CMS recommendations for improvements. We strongly recommend that the agency improve its oversight in the implementation of this particular policy because it did not accurately identify Hurricane Harvey-affected physicians in some of the 53 disaster-designated counties in Texas. For example, the CMS fact sheet about the 2017 Extreme and Uncontrollable Circumstances Policy for MIPS states, "We'll be able to automatically identify you. If you're an affected MIPS eligible clinician, you'll automatically receive a neutral MIPS payment adjustment," meaning no negative payment adjustment in 2019. However, we were informed that several physicians who were affected by Hurricane Harvey were mistakenly applied the full 4-percent negative payment adjustment for 2019.

TMA recommends that CMS ensure the negative payment adjustment is removed for affected physicians and that a neutral payment adjustment is applied as described in the policy. We also recommend that the agency do more to inform physicians in a timely manner about known issues pertaining to this policy during the performance feedback and targeted review period. For future events, we further recommend that CMS communicate this policy directly to affected physicians such as through the QPP portal in addition to email and the QPP website. That way, affected physicians who have the time to check their status in the QPP portal, can be informed of the flexibilities and options afforded to them under this policy so they may better focus their efforts on patient care and/or rebuilding their practices rather than on the burden of collecting and submitting data to CMS.

TMA Recommendation: CMS should ensure that Hurricane Harvey-affected physicians do not mistakenly receive the 4-percent negative payment adjustment in 2019.

ALTERNATIVE PAYMENT MODELS

Transition to Advanced APMs

TMA believes APMs and Advanced APMs must be designed to attract physicians to participate voluntarily in programs proven to help them treat their Medicare patient population more effectively. CMS estimated that 70,000 to 120,000 clinicians nationally would qualify for the APM incentive payment for the 2017 performance year and recently announced that 99 percent of 100,000 clinicians qualified for it. The agency also estimated that 185,000 to 250,000 eligible clinicians nationally would qualify for the 2018 performance year, and 160,000 to 215,000 would qualify for the 2019 performance year. Considering these estimates, we note that participation in APMs appears to have stalled, and we are concerned that opportunities in the APM pathway and the 5-percent APM incentive payment will continue to be limited to just a few physicians and specialties.

Currently only a limited number of Advanced APM offerings are accessible to a broad range of physicians and medical specialties, including models with a slow ramp-up to financial risk. No new innovative models are set to launch in 2019. Until additional APM models are tested and proven, we reiterate that physicians should not be forced to accept more risk than they can financially manage. Rather, APMs should allow physicians to assume appropriate financial risk for reducing costs proportional to their finances while offering greater reward over time for practices that agree to take on more risk.

TMA Recommendation: As physicians transition to Advanced APMs, CMS policies should allow physicians to assume appropriate financial risk for reducing costs proportional to their finances while offering greater reward over time for practices that agree to take on more risk.

Limited Availability of Physician-Led Models of Care and Advanced APMs

MACRA created a pathway for physicians to propose innovative payment models to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). If the committee regarded the model to have merit, it would then make comments and recommendations to the Secretary. To date, PTAC has received approximately 20 proposals. Although 10 of them were recommended to the Secretary to move forward for either limited scale testing or implementation, none have been tested or implemented.

TMA supports the development of physician-led models of care and Advanced APMs. We also support the concept of community-based APMs emphasizing meaningful access for patients throughout Texas. Because many physicians have expressed a desire to develop their own proposals to promote innovation in health care, CMS should provide more education and technical assistance pertaining to the PTAC process.

We note that the 5-percent incentive payment for participating in an Advanced APM is available only for the 2019-24 payment years. Lacking a sufficient number of Advanced APMs and with no innovative models being tested or implemented under the PTAC process, many physicians will be unable to take advantage of the added incentives and may stay away from Advanced APMs. As we approach the third year of the QPP, it is imperative that CMS improve its efforts to create Advanced APMs, including models that have a low barrier to entry and slow and gradual ramp-up to risk.

TMA Recommendation: CMS should prioritize physician-led models of care and Advanced APMs that offer participation opportunities for physicians in all specialties and practice sizes.

Increasing the CEHRT Use Criterion for Advanced APMs

CMS is seeking comments on the proposal to increase CEHRT requirements in Advanced APMs from 50 percent to 75 percent of eligible clinicians in each APM Entity.

We support CMS' goal to prioritize interoperability, which allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable law. However, we believe that an increase of 25 percent at this time would hurt current participants.

CMS has stated that the ultimate goal is for a majority of physicians and other clinicians to participate in APMs. However, we believe significantly increasing CEHRT requirements will discourage participation because of the high costs of implementing EHRs. We believe a 25-percent increase is a steep demand and burdensome requirement that would threaten Qualifying APM Participant (QP) eligibility for many Texas physicians and clinicians. We further believe this increase will not be achievable if CMS significantly increases the use of CEHRT requirements. Instead, TMA supports a more steady and gradual increase in CEHRT requirements to allow physicians with an achievable pathway to QP status in an Advanced APM.

TMA recommendation: CMS should maintain the 50-percent CEHRT use requirement for the third performance year, especially to engage small and rural practices as well as first year participants in Advanced APMs.

MIPS Comparable Measures

CMS proposes to require that the quality measures upon which an Advanced APM bases payment be: 1) on the MIPS final list, 2) endorsed by a consensus-based entity, or 3) otherwise determined to be evidence-based, reliable, and valid by CMS in order to be considered MIPS comparable. This would eliminate two current criteria: whether the measure was 1) submitted in the annual call for quality measures, or 2) developed using QPP development funds.

TMA seeks clarification on what criteria CMS will use to define "evidenced-based, reliable, and valid" and what type of professionals, physicians and/or clinicians would make these decisions because we strongly oppose the agency's plan to determine MIPS comparable quality measures independently.

In general, TMA opposes the use of any designated MIPS comparable quality measure in the Advanced APM pathway 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*. We believe all measures must be adequately vetted using a transparent and valid process, with input from the medical profession and relevant stakeholders. 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. In addition, we believe practicing physicians must be actively involved not only in the development of measures used for performance measurement but also in the selection of quality measures used in MIPS and Advanced APMs under the QPP.

TMA Recommendation: All MIPS comparable quality measures for the Advanced APM pathway should go through a fair and standard vetting process open to the medical profession rather than independently determined and approved by CMS.

Nominal Risk Amount

CMS is requesting comments on the proposal to maintain the generally applicable revenue-based nominal amount standard at 8 percent of the average estimated total Medicare Parts A and B revenue of all physicians, providers, and suppliers in participating APM Entities for the 2021-24 QPP performance periods.

Although we acknowledge that some physicians are in a position to assume the 8-percent nominal amount standard, we continue to urge CMS to set a lower nominal risk amount for small practices and others in rural areas. We believe a lower risk amount is necessary to ensure that the challenging operational risks and expenses — such as training of staff, information technology maintenance, and other overhead expenses — that put these practices at greater financial risk than larger practices, are not a hindrance for participation in Advanced APMs.

CMS is also seeking comments on whether it should consider raising the revenue-based nominal amount standard to 10 percent, and the expenditure-based nominal amount standard to 4 percent for QP performance periods in 2025 and later. TMA opposes this proposal and instead recommends that CMS wait until it has further data to inform the right increase at the right time.

TMA Recommendation: CMS should have a lower nominal risk amount for physicians in small practices and rural areas.

Qualifying APM Participant (QP) and Partial QP Determinations

The Agency is proposing that for each of the three QP determinations (March 31, June 30, and August 31), it will allow for claims run-out for 60 days (approximately 2 months), before calculating the threshold score so that the three QP determinations will be completed approximately 3 months after the end of that determination time period.

We support CMS in its effort to provide QP status notifications to physicians more quickly after each of the three QP determination snapshot dates, and prior to the beginning of the MIPS data submission period after the last determination. Because this change will impact claims processes, we recommend that CMS inform physicians of the new claims run-out timeframe in a timely manner to ensure they adjust their claims processes accordingly.

TMA Recommendation: CMS should inform physicians of the new claims run-out timeframe in a timely manner to ensure they adjust their claims processes accordingly.

CY 2018 Exclusion of MIPS Eligible Clinicians Participating in the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration

Some Medicare Advantage plans have developed innovative arrangements that are very closely aligned with and resemble Advanced APMs, but physicians who participate in these plans are still subject to MIPS. The MAQI Demonstration would test waiving MIPS reporting requirements and payment adjustments for physicians who participate sufficiently in Medicare

Advantage arrangements that are similar to Advanced APMs. The MAQI Demonstration would also test whether participation in payment arrangements with Medicare Advantage Organizations would change the manner in which physicians deliver care. TMA supports the MAQI Demonstration as it offers greater flexibility for physicians by creating another pathway for participation in the QPP. However, we urge CMS to consider extending the MAQI Demonstration application deadline for physicians who are just now learning about this opportunity.

TMA Recommendation: CMS should implement the MAQI demonstration as it offers greater flexibility for physicians by creating another pathway for participation in the QPP.

PHYSICIAN EDUCATION ON THE QPP

Considering the overall program complexity of the QPP and annual changes to data requirements, terminology, and policies that are not finalized until two months before each performance period, TMA offers additional comments pertaining to physician education and technical assistance.

We note that to learn about the different aspects of the MIPS and APM pathways, physicians currently may turn to the following websites and organizations for information, education, and/or technical assistance: 1) QPP website; 2) CMS website, 3) Center for Medicare and Medicare & Medicaid Innovation, 4) Transforming Clinical Practice Initiative, 5) Health Care Payment Learning and Action Network, 6) Quality Improvement Organization-Quality Innovation Network, and 7) Small, Urban and Rural Support.

We appreciate the work of CMS and HHS on these initiatives and websites. However, in spite of all of these education efforts, we continue to hear from many physicians that the program is overly complex, and learning and understanding the details of the QPP is time-intensive and takes away from their busy patient care schedules. They must read and review numerous fact sheets, guides, webinars, infographics, instructional videos, and other materials that oftentimes are published throughout the performance year rather than at the beginning of the year or within the context of a predictable timeframe. Not surprisingly, physicians report that learning about and navigating the MIPS and APM pathways is very challenging, confusing, or simply not feasible.

The feedback we hear most is that physicians do not have time to read the 1,000-plus pages of the annual proposed and final rules and the hundreds of pages of CMS resources and guides that are valid only for a short period of time due to the ever-changing QPP data and program requirements. Physicians report they are in search of one comprehensive physician education initiative accredited with formal continuing medical education (CME) credits that covers everything they need to know about the QPP. Physicians want all education pertaining to each performance year readily available before or at the start of each performance period so they can adequately prepare to meet all data requirements and engage meaningfully in the QPP.

In addition to the available initiatives and websites noted above, TMA also engages in many efforts to educate Texas physicians and collaborates with other professional organizations and consulting firms to bring our members the best education possible. Given that CMS is the authoritative source, we rely on the QPP proposed and final rules and CMS QPP websites for accurate information to create high-quality physician education. However, we inform the agency that its practice of publishing documents and holding webinars in piecemeal fashion over the course of the calendar year makes it challenging and difficult for us to develop timely educational materials for our members. For all of these reasons, TMA urges CMS and HHS to make significant improvements to their overall education efforts on the QPP.

TMA Recommendation: To help physicians learn about, navigate, transition, and participate successfully in the MIPS and APM pathways under the QPP, CMS and HHS should improve its education efforts, develop and implement a comprehensive physician education initiative, with CME credit, and make all education materials readily available before or at beginning of each performance year.

Conclusion

We appreciate the opportunity to comment on this proposed rule. While we addressed key areas common to all physicians, our comments have not addressed many provisions that may be of primary concern to physicians in various specialties. With regard to these matters, we again defer to specialty societies who have the relevant clinical expertise to evaluate the rules. If you should have any questions or need any additional information, please do not hesitate to contact us or these staff members at the Texas Medical Association: Darren Whitehurst, TMA Vice President of Advocacy, or Karen Batory, TMA Vice President of Population Health and Medical Education, at (512) 370-1300.

Sincerely,



John G. Flores, MD
Chair, Council on Socioeconomics
Texas Medical Association



Jeffery B. Kahn, MD
Chair, Council on Health Care Quality
Texas Medical Association