



Physicians Caring for Texans

Sept. 27, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1715-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

VIA ELECTRONIC SUBMISSION

RE: CMS-1715-P, Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations

Dear Administrator Verma:

On behalf of the Texas Medical Association (TMA), I am pleased to offer comments and recommendations in response to the Centers for Medicare & Medicaid Services (CMS) 2020 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule as published in the *Federal Register* on Aug. 14, 2019.

TMA is the largest state medical society in the nation and is the voice of nearly 53,000 physician and medical student members across the state committed to improving the health of all Texans. In partnership with 110 county medical societies, TMA physicians have been setting high professional and ethical standards since 1853. It is the mission of TMA to stand up for Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients.

We offer our comments, recommendations, and suggestions in the spirit of improving the 52-year-old Medicare program that covers health care costs for some 59 million Americans, including more than 4 million Texans. As an organization of physicians (many of whom deliver this care), we believe it is imperative to offer our frank and constructive comments. Like you, our goal is to ensure all Medicare beneficiaries receive high quality, cost-effective care. That cannot happen if our Medicare patients lack appropriate and timely access to physicians of all specialties.

Based on my own 28 years of experience as a practicing colon and rectal surgeon, and on both analytical and anecdotal research with our members, I can emphatically state that Medicare patients' access to physicians is at risk. Medicare payments to physicians have stagnated for most

of this century, and promised pay increases have vanished in the wake of cost-cutting actions by Congress and CMS. Meanwhile, the administrative burdens and costs of participating in Medicare have increased year after year.

This is an unsustainable trend. All of us – physicians, patients, providers, elected officials, and your agency – must work together to reverse that trend if Medicare is to continue to keep its promises to the senior citizens and individuals with disabilities who depend on it.

In that spirit, and in the best interests of Texas physicians and our patients, we ask that you favorably consider our recommendations. (I summarize those recommendations below; we offer more detail, rationale, and references in the attached comments.)

Please note that we are not commenting on various RVU revisions and other proposed changes that are specialty-specific. We urge you to carefully consider comments from specialty societies on these subjects where they have particular expertise not common to all physicians.

TMA's principal comments and recommendations for the 2020 PFS and QPP proposed rule are as follows:

- TMA supports CMS's decision not to move forward with compressing the evaluation and management codes. CMS is making the right decision to follow the recommendations of the RVS Update Committee (RUC).
- TMA recommends that CMS require written consent for technology-based services annually, not at every point of service.
- TMA believes CMS must enhance beneficiary education regarding patient cost-sharing responsibilities.
- TMA strongly encourages CMS to correct the problems with the geographic practice cost index (GPCI) calculations and advocate for Congress to permanently extend the 1.0 floor to states that do not have a permanent floor. We also recommend CMS revise the GPCI payment localities using metropolitan statistical area data to determine boundary changes.
- TMA strongly opposes CMS expanding its authority to encroach on state medical boards' responsibility and authority to regulate physicians and protect patients.
- TMA is pleased CMS did not propose to decrease the low volume threshold, which would have required more physicians to participate in the Merit-Based Incentive Payment System (MIPS). TMA urges CMS to increase the low volume threshold for the 2020 performance year and beyond, and to exempt small practices from required participation in MIPS.
- TMA applauds and fully supports CMS' proposal to establish a physician-friendly policy that will allow physicians an opportunity to have their performance category reweighted when data errors are made by vendors or others.
- TMA urges CMS to revamp its policies and protocols to correct the payment delays and administrative delays and errors that have frustrated those physicians who are dedicated participating in QPP and its various components.

- TMA urges CMS to intensify its efforts to streamline and simplify all aspects of QPP participation. We believe the ongoing compliance, documentation, and reporting necessary to score well in the QPP are costly and wasteful, with no proven evidence of benefit.
- TMA urges CMS to eliminate QPP measures based on actions or outcomes that are not in physician control, as well as those measures that penalize physicians who disproportionately treat patients from disadvantaged populations.
- TMA opposes the proposal to remove 55 MIPS quality measures for the 2020 performance year unless such measures are out of physician control, penalize physicians who disproportionately treat patients from disadvantaged populations, or are impacted by socioeconomic variables or social determinants of health.
- TMA urges CMS to provide a transparent, accurate, and complete QPP experience report annually.
- TMA strongly encourages CMS to eliminate the all-or-nothing approach to the Promoting Interoperability (PI) category score so that physicians receive credit for measures met.
- CMS should not add objectives or measures to the PI category that require the overly burdensome capture of patient-generated health data (PGHD).
- CMS should fund a national, nongovernmental aggregator of HIT-related patient safety events, with liability protections for physicians who report those events.
- MIPS Value Pathways (MVPs) should be defined using TMA's recommended guiding principles.
- TMA urges CMS to pilot test MVPs and phase-in program implementation over the course of several years.
- CMS should prioritize physician-led models of care and advanced APMs that offer participation opportunities for physicians in all specialties and practice sizes.

In conclusion, I repeat my earlier comment: Like you, our goal is to ensure all Medicare beneficiaries receive high quality, cost-effective care.

We stand ready to provide the agency with detailed examples of the concerns we raise and will gladly share our policy expertise and whatever additional assistance you might find of use. Feel free to contact me at the address above or by email at president@texmed.org, or reach out to Darren Whitehurst, TMA VP for Advocacy, at (512) 370-1350.

Sincerely,

A handwritten signature in black ink, appearing to read "David C. Fleeger". The signature is fluid and cursive, with a large initial "D" and "F".

David C. Fleeger, MD
President

Attachment

COMMENTS OF THE TEXAS MEDICAL ASSOCIATION

Re: CMS–1715–P, Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations

PHYSICIAN FEE SCHEDULE

Evaluation and Management (E&M) Code Changes

TMA commends CMS for stepping back from its 2019 proposal and working with stakeholders to update E&M codes in a meaningful way. TMA supports the proposed changes to these codes made for 2021 as well as the add-on code to account for additional time physicians may spend with patients during a level 5 visit. TMA also supports the changes proposed for the 2021 work relative value units (RVU). CMS has long devalued office visit payments. An increase to the work RUVs is a positive step in establishing a more appropriate payment for these services.

Recommendation: CMS should move forward with the proposal to follow the AMA/Specialty Society RVS Update Committee’s (RUC) recommended changes to the E&M codes for 2021.

Communication and Technology-Based Services

TMA commends CMS for taking another step to modernize how care is delivered to Medicare patients. Paying physicians for the communication and technology-based services helps to ensure continued practice viability. However, as we noted in our comments on the 2019 proposed rule, we are concerned about the financial impact this will have on patients.

Physicians and providers have been delivering care to patients via technology for quite some time. Many physicians speak with patients via phone, review images patients send, and engage in interprofessional consults for the benefit of treating their patients – but without the benefit of payment. Patients frequently check in with their physicians via phone or via sent images because of struggles with transportation or delayed access to care due to their physicians having fully booked schedules. Medicare patients are now accountable for the cost share portion of the physicians’ fee. As mentioned in our 2019 comments, TMA is concerned that Medicare beneficiaries will avoid or delay care because they will be charged for a service that historically has been not billed separately. This avoidance and/or delay in care will lead to an overall increase in cost of care.

While CMS recognized the need for paying physicians for these services, the agency added a significant administrative burden with its decision to require consent (and documentation of

consent) for each occurrence. TMA expressed our concerns about this undue burden in previous comments. This concern is especially true for physicians who are consulting and do not have an established relationship with the patient. Because CMS did not heed TMA's and other stakeholder's warnings, the agency has continued to receive feedback stating it is overly burdensome to obtain advance verbal consent each time the service is delivered and to document this consent in the medical record. Consent for these technology-based services should be obtained in writing once a year from each patient. The consent should include acknowledgement that:

- the patients will be responsible for their 20% cost sharing, after meeting their deductible,
- the consent includes consults with other physicians the patient may not have seen, and
- the patient can revoke the consent in writing at any time (provided that the revocation is not effective for services previously received).

The 2020 proposal reiterated that patient cost sharing remains a part of these newly recognized services. As mentioned in previous comments, suddenly charging Medicare beneficiaries for services that have always been included as part of a care delivery model and not billed to them separately may cause patients significant financial harm. TMA continues to be concerned about patients delaying care due to new financial concerns.

Recommendation: CMS should require written consent for these services one time a year. This can be renewed and updated each year with minimal added burden to the physicians. Additionally, patients should be able to revoke this consent in writing at any time (provided that such revocation is not effective for services already received). CMS should do more patient education on these new services so that patients understand the consent process and their financial responsibilities.

Coinsurance for Colorectal Screening Tests

CMS finally recognizes the financial confusion that patients experience when a preventive colorectal cancer screening turns into a diagnostic procedure. Since this occurs mid-screening, physicians are not able to alert patients that they now will have a financial responsibility for a service they had understandably expected to be 100% covered by Medicare. TMA believes physicians explain before the procedure that while colorectal cancer screenings are advised, they can become diagnostic procedures and generate cost sharing for patients. In spite of physician efforts to educate patients, the final responsibility remains squarely on CMS' shoulders to explain to enrollees their benefits and financial responsibilities for the services they receive. It is not the physician's responsibility to explain a patient's health benefit plan. CMS should not mandate that physicians provide any type of health plan or insurance education to their patients. While physicians do discuss financial factors of treatment plans with their patients, such mandates are an overreach and harm the sacred space of the physician-patient relationship.

Recommendation: CMS should educate patients on their cost sharing responsibilities. The agency should clearly articulate a patient's financial responsibility when a colorectal cancer screening becomes a diagnostic procedure. CMS should not add additional administrative burdens through mandating physicians educate patients on their individual health plans and document this education.

Work GPCIs Changes

The methodology for calculating the physician work geographic practice cost index (GPCI) currently uses salary data for individuals with 5 or more years of college, rather than the data for those with graduate degrees. The original rationale for that choice was that the latter data was not statistically reliable for very small payment areas. Since the payment areas were aggregated in 1997, this problem should have been eliminated. CMS should re-evaluate the feasibility of using salary data for individuals with advanced degrees in the GPCI calculation.

The adjustments for the physician work component currently treat all physician compensation as salary, although a portion of physician compensation from medical practice is in fact a return on the physician's investment in the practice. As physician practices become more capital and labor intensive, physician investment in office, equipment, and operating capital becomes larger, requiring a larger return in order to be economically prudent. Allowance should be made in the update factors for increases in the cost of capital.

Congress has not passed an extension of the 1.0 floor for work GPCI, thereby causing a decrease for 2020 and 2021. This negative effect is further exacerbated by CMS' already flawed work GPCI calculations. The 1.0 floor must be reinstated effective Jan. 1, 2020. CMS should encourage Congress to permanently extend the 1.0 floor to states that don't already have a permanent floor.

Recommendation: CMS should correct the work GPCI calculations to consider only data for individuals with graduate degrees. It also should consider that physicians invest a portion of their compensation in the practice. This portion should not be counted as salary. Finally, CMS should encourage Congress to permanently extend the 1.0 floor to states that do not already have a permanent floor.

GPCI Localities

In spite of recommendations by the Government Accountability Office and the Institute of Medicine as well as repeated studies of the problems with the current localities, CMS has failed to revise payment localities. This has created increasing distortions in the payment system as urban areas have grown and local cost factors have changed dramatically. The fact that California advocated for and received legislative intervention to attain locality revisions does not solve the problem, but illustrates its importance and highlights the urgency. This problem must be addressed everywhere and not just in California.

The GPCIs cannot be accurate or meaningful until localities are revised. Large cuts to rural and rest-of-state areas should be avoided or minimized, but locality boundaries with large payment differences should not cut through the middle of urban areas. In many areas of Texas, locality boundaries that fall within seamless urban areas create "payment cliffs" where payment can change by up to 6% 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. Implementing locality definition changes based on Metropolitan Statistical Areas (MSA) or on

hospital localities or on similar methodology recommended in the many previous and ongoing studies will correct these “payment cliffs.” Because the locality updates have been delayed for 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 payment distortions are not reintroduced by population change.

CMS also should evaluate the need to create some new payment areas in Texas to allow better tracking of local economic conditions. As you acknowledge, urban areas generally have higher costs than rural areas. Yet San Antonio, one of the largest urban areas in the nation, was aggregated into the “Rest of Texas” area in 1997, simply because, at that time, the costs indices for San Antonio were not sufficiently different from the rural areas to meet an arbitrary threshold. No matter how the costs for San Antonio compare to other areas at any one point in time, it should stand alone in its own payment locality so that the relevant geographic adjustments can accurately reflect local economic conditions. Other urban areas in Texas, particularly those that have been assigned to MSAs, also should be evaluated to determine the need for additional new localities.

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. TMA also continues to recommend that CMS reevaluate existing databases to find or develop a nationwide measure of commercial office rents for use in calculating practice expense GPICs.

General Fee Update

While Medicare fee updates are controlled by congressional action, it is very disappointing that the fee updates that were ostensibly promised in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) once again will not be forthcoming. The recent history of and future plans for inadequate fee updates, paired with the growing Medicare administrative burden, makes Medicare participation and compliance increasingly difficult and costly for practicing physicians, and may 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 significantly decreasing Medicare payment adequacy. Medicare estimates market-basket cost increases in calculating a Medicare Economic Index (MEI), which has historically increased approximately 2% per year. The MEI is used to calculate fee updates for hospitals, nursing homes, and other facilities, to ensure that their cost increases are covered. This same standard must apply to physician payment.

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. Increases in administrative complexity are making Medicare participation an increasingly less attractive proposition to the smaller-sized practices common in Texas. Although almost all physicians will treat some Medicare beneficiaries, even if only when they take emergency room call, the 2018 TMA survey shows 29 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 less sustainable and Medicare business increasingly less attractive for physicians. Medicare beneficiaries who cannot access outpatient physician care will be more likely to seek care in emergency rooms, driving total Medicare costs higher.

Recommendation: TMA recommends CMS mitigate the increasing administrative burdens and costs of participating in Medicare. CMS must reduce the overwhelming costs and burdens of its highly distorted and fundamentally flawed quality program.

Medicare Enrollment or Billing Privilege Revocation

CMS is rightfully concerned about preventing patient harm and protecting Medicare patients. Revoking a physician's ability to bill for services rendered to Medicare patients is a method used to enforce those concerns. Currently, CMS uses information from a final determination made by a regulatory board or agency to make these decisions. The current system was established to afford a mechanism for full information discovery and due process before the board or CMS made any decisions. This system also appropriately relies on state medical boards to make the right decisions in protecting patients and regulating the practice of medicine.

Physicians are professionals who undergo rigorous and extensive training and education to practice medicine. Much of this is not to only train the physician but also to protect the patient. In addition, physicians must submit to a state licensing and oversight body to practice medicine. While there are a few bad actors in every industry, the current regulations provide a balance of protection to patients and due process to physicians. CMS should not be handing down expansive punishments to physicians for complaints that have not been resolved or for minor infractions such as administrative issues.

CMS' proposal to expand its own authority is a significant and damaging overreach. The proposed change states physicians should not assume that minor infractions will place them in CMS' crosshairs, but really, no other assumption can be made. CMS has declared that it is the only body that is responsible for preventing harm to Medicare patients. This ignores the fact that all 50 states charge their medical boards with this responsibility. To assert that CMS is the only body that can be trusted to protect Medicare patients is at odds with the long-standing patient-protection function of state medical boards and state-based regulation of the medical profession. TMA opposes CMS' decision to arbitrarily expand its authority.

Recommendation: CMS should not expand its own authority to deliver punishments to physicians for any infraction as it sees fit, encroaching on the well-established jurisdiction of state medical boards.

QUALITY PAYMENT PROGRAM

Overview

TMA appreciates the opportunity to comment on the updates and proposals for the 2020 Quality Payment Program (QPP) and future years of the program. The 2020 QPP performance year will mark the fourth implementation year for the provisions set forth by MACRA and its Merit-Based Incentive Payment System (MIPS) and alternative payment model (APM) tracks. According to CMS estimates in the proposed rule, participation in Advanced APMs (175,000-225,000) will increase next year, but an overwhelming majority of clinicians will continue to participate in MIPS (818,000), either directly or as part of a MIPS APM. While this is good information to know, these estimates do not tell us where we are as a state in Medicare's transition to value-based care. While we acknowledge that the QPP is a federal program, TMA urges CMS to provide state-level data that show where Texas physicians may stand in the fourth year of MACRA implementation to inform our comments and recommendations moving forward.

Many Texas physicians have made a good faith effort to learn about the QPP, stayed abreast of ever-evolving changes, and have submitted data annually with the hope that the program would indeed benefit their Medicare beneficiaries and financially reward their practices. However, we remain disappointed in CMS' highly flawed and complex program that a great majority of Texas physicians believe lacks appropriate methodologies, uses poor measures, and falls short of benefiting their patients. For example, TMA's 2018 Survey of Texas Physicians¹ on the QPP showed that:

- 74% of Texas physicians believe CMS should discontinue incentives and penalties until it appropriately risk adjusts for socioeconomic variables or social determinants of health,
- 71% of Texas physicians believe CMS should discontinue efforts to score or reward practices until better measures are available, and
- 65% of Texas physicians believe the program will not improve patient care quality.

We believe CMS must do more to create a level MIPS playing field among physicians in practices of all sizes, settings, and locations. Data provided in the 2017 QPP experience report showed that 2019 MIPS incentive payments are funded mostly off the backs of clinicians in small and rural practices nationwide. This outcome is unacceptable to TMA as small practices currently comprise 73% of physician practices in Texas (defined as eight physicians or fewer)². CMS' own estimates in the 2020 proposed rule continue to show that physicians in solo and small group practices will disproportionately receive the payment penalty. All of this evidence suggests the program is highly flawed and inequitable, and threatens access to care in the very communities and rural settings where health care resources are limited and physician workforce shortages exist.

Since the launch of the QPP in 2017, CMS reports it has taken a steady approach to implementation while taking into consideration the unique differences in physician practices to reduce reporting burden, encourage meaningful participation, and improve patient outcomes. Yet

¹ TMA 2018 Survey of Texas Physicians <https://www.texmed.org/Template.aspx?id=16236>

² TMA 2018 Survey of Texas Physicians <https://www.texmed.org/Template.aspx?id=16236>

the QPP is more complex than ever, and based on the proposals and updates for 2020 and future years, the program will to evolve into an even more complex state by transforming MIPS through the MIPS Value Pathways (MVPs), which will further burden physicians to learn about a new program with different data requirements. Each round of change comes without any federal data that show the program is meeting the aims Congress envisioned with MACRA, such as improving the care and population health of Medicare beneficiaries, lowering Medicare costs, and minimizing burden on practicing physicians.

While the proposed MIPS Value Pathway (MVP) framework may sound promising on the surface, TMA has heard this before. The association reminds CMS that with every QPP proposal and final rule it has published since MACRA, the agency continues to tout its policies and overall program as the very best for improving quality, reducing costs, and minimizing physician burden. With all due respect, however, it remains to be seen whether the agency will ever achieve such objectives and implement a federal program that does not result in harm to a subset of physicians – and their patients – in the process.

We believe policies for the fourth year of MACRA implementation are just as important as CMS proposes to transition physicians from regular MIPS to the MVP framework in 2021. Given that the payment penalty will increase to 9%, it is imperative that the agency not lose sight of simplifying and improving the program for the 2020 QPP performance year. Under the right circumstances, TMA believes Texas physicians can move the needle toward an advanced state of clinical care delivery that contributes to the shared goal of improving the health of their patients in a manner that is safe and effective for all Medicare beneficiaries. Ideally, the QPP should empower physicians with timely, meaningful, and actionable data based on a fair and equitable assessment of performance, using measures and activities physicians find meaningful to their practices. QPP should help physicians drive improvements in care quality among their Medicare beneficiaries without fear of failure or penalty. For these reasons, TMA urges CMS to improve the program by implementing policies that are fair and ethical³, include adequate risk adjustment⁴ for quality and cost metrics as required by statute, further simplify electronic health record (EHR) requirements, relieve physician burden, and most importantly, result in an overall program that truly improves patient care quality.

Lastly, we understand that the solution to many of the program's problems will require congressional action, but we urge you to continue to use your regulatory authority to mitigate the negative impact in every way possible.

General Program Concerns

Poor Program Implementation, Administrative Errors, and Delays

CMS should be viewed as a reliable agency and trusted source for complete and accurate data and information surrounding the QPP. However, MACRA implementation has been riddled with problems since the launch of the program in 2017. CMS should be forthcoming with the fact that moving Medicare physicians and other clinicians to a value-based payment system has been a

³ TMA Policy 265.017 Pay-for-Performance Principles and Guidelines <https://www.texmed.org/Template.aspx?id=43393>

⁴ TMA Policy 195.033 Medicare Payment Incentives and Penalties <https://www.texmed.org/Template.aspx?id=43134>

complex and difficult undertaking full of challenges and missteps at different stages of implementation that result in increased physician burden.

For example:

- Delay in informing physicians well after the performance years had started whether they are MIPS-eligible and required to participate in the program for the 2017, 2018, and 2019 QPP performance years, resulting in a delay in clinical readiness, compromising performance, and ultimately affecting payment adjustments,
- Delay in updating the QPP website with the latest information, data requirements, and resources until well after the 2017, 2018, and 2019 performance years had begun, hindering physician engagement and resulting in uncertainties about data requirements and other pertinent information physicians need to successfully participate in the program,
- Errors in 2017 MIPS performance feedback and the need to recalculate scores and revise 2019 payment adjustments, resulting in physicians having to interrupt their patient care schedules to recheck their MIPS final scores, performance feedback, and payment adjustments and file a targeted review request if needed, and leaving them to question whether their final scores and payment adjustments were indeed accurate the second time,
- Errors in implementing MIPS payment adjustments over several months in 2019 based on 2017 performance, resulting in payment uncertainties, overpayments, recoupments, and increasing physician burden,
- Delay in issuing the 5% bonus payments in 2019 for physicians who took part in Advanced APMs in 2017 as required by MACRA, resulting in postponement of payment that is intended to help cover physicians' continued investments in practice transformation efforts to support their ongoing participation in Advanced APMs. (As of Sept. 20, 2019, the 5% lump sum bonus payments had not been paid to the 99,076 clinicians who achieved qualifying APM participant status in Advanced APMs in 2017.)

Errors or delays of that magnitude by physicians would result in MIPS payment penalties and/or recoupments or additional Medicare penalties for failed audits. When conducting QPP data validation and audits, TMA urges CMS to take into account the learning curve involved for physicians and the circumstances in which the agency puts them that affect their ability to comply with the program's multitudinous and growing requirements. TMA believes that audits should be educational in nature rather than punitive. We also emphasize the importance of accurate and timely physician payment for both the MIPS and APM tracks.

Recommendation: To reduce physician burden and foster continued engagement in the QPP, TMA urges CMS to improve its administrative policies and protocols to mitigate issues surrounding program implementation, such as ensuring accurate and timely physician payment for both the MIPS and APM tracks, expediting MIPS eligibility status and QPP website updates, and making audits educational in nature rather than punitive.

Inadequate Experience Report and Lack of Program Transparency

As detailed in the letter^{5,6} TMA and seven other state medical societies sent to CMS in April, we are disappointed with the 2017 QPP experience report published in March 2019 and overall lack of program transparency. TMA is further disappointed that CMS declined our six recommendations to improve its approach, beginning with rescinding the report.

We reiterate that because of the limited data, we are unable to fully evaluate the transition to value-based care and APMs in the state of Texas, nor can we determine whether program and scoring policies and data requirements are truly fair or warrant further policy changes. TMA found it troubling that CMS conducted such poor analyses and evaluation of the first year of MACRA implementation and did so with little regard to the serious threat the payment penalties pose to physician practices nor to the potential harm to continued physician participation in Medicare and to beneficiaries' access to care.

The 2017 QPP experience report results showed that of the 62,731 MIPS-eligible clinicians in Texas, 44,829 participated directly in MIPS. 16,072 participated through a MIPS APM, and 1,830 did not participate at all. Of the 62,731 MIPS-eligible clinicians, 45,804 were physicians; 32,636 participated in regular MIPS, and 11,831 participated in MIPS APMs. CMS provided no state-level data showing which MIPS APMs Texas physicians participated in, how many physicians participated in Advanced APMs and which models those were, or how many physicians were exempt due to the low-volume threshold policy or because they were newly enrolled in Medicare. Furthermore, CMS also counted physicians who were affected by Hurricane Harvey and effectively exempt from submitting data as having "participated" in MIPS. The agency provided no state-level data describing the difference between those who submitted data from those who were given an automatic three points due to the natural disaster. In addition, there were no state or national data in the report for many other aspects of the program. Even after CMS followed up with an accounting of national data for the extreme and uncontrollable circumstances policy, data discrepancies remained which further validated our concerns that the agency's overall 2017 QPP program results and data are flawed and inaccurate.

TMA urges CMS to make improvements to its annual experience report, including data that show disparities among all physician practices, so we can identify policies that may need to be modified to achieve a level playing field. Specifically, the agency should issue a report prepared by independent professionals who understand the program from a global perspective, as well as the nuances that make it so complex to be able to identify and report on the necessary data elements.

Lastly, given that overall QPP performance data are not found in any other federal document or in the current proposed rule, and because TMA and other stakeholders who comment on proposals need such data, it is imperative that CMS use the QPP experience report to provide objective data rather than use it as marketing tool for the program. We believe the report is a

⁵ TMA-led Coalition Letter in Response to the CMS 2017 QPP Experience Report. (April 2019). https://www.texmed.org/uploadedFiles/Current/2016_Practice_Help/Clinical_Quality_and_Payment/MACRA/CoalitionMACRALetter4-25-19.pdf

⁶ False Impression: Medicine Says Medicare Report Inflates Success of Quality Program. *Texas Medicine*. (June 2019). <https://www.texmed.org/Template.aspx?id=50662>

vital federal document that gauges whether the QPP under MACRA is designed fairly and properly as an effective program to incentivize physicians to improve outcomes and reduce costs among Medicare beneficiaries.

Recommendation: TMA urges CMS to improve its transparency by providing a transparent, accurate, and complete QPP experience report annually so the all stakeholders can analyze national and state data to advocate for additional exemptions, flexibilities, and reductions in reporting burdens, administrative hassles, and costs.

Cost of Reporting, Return on Investment, and Budget Neutrality

We continue to be concerned that the ongoing compliance, documentation, and reporting necessary to score well in the QPP are costly and wasteful with no proven evidence of benefit. Many physicians have made significant investments and put forth a good faith effort to transform their practices to participate in the QPP. However, an independent analysis shows that for many practices, compliance costs for all aspects of program participation exceeds any likely financial return on investment through incentives and avoided penalties.⁷

Many of the associated costs are subject to economies of scale, so they become cost-effective only for larger physician groups. One example is the cost to contract with vendors to collect and report Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data. In the 2019 QPP proposed rule, CMS reported that costs to contract with a CMS-approved CAHPS vendor range from approximately \$4,000 to \$7,000 – depending on services requested – per group practice per performance year. While these vendor fees may be affordable to ACOs and large group practices, they are prohibitively costly for physicians in small group practices, even more so when there is no return on investment. Because of these high costs and others reasons, TMA continues to advocate that the CAHPS for MIPS survey remain optional.

By law, the MIPS payment adjustment (bonus or penalty) will increase to 9% for the 2022 payment year based on the 2020 performance year, and will remain at 9% for future years of the program. MIPS bonuses, however, will remain limited over the next few years. Notably, the maximum MIPS bonus was only 1.88% in 2019 and will be a mere 1.68% in 2020. These bonuses disappear when you factor in the ongoing 2% Medicare sequestration and the cost of reporting.

We acknowledge that the low-volume threshold policy and other factors affect MIPS bonuses, but assert that the fundamental flaw in MACRA is the budget neutrality requirement. As the QPP evolves over time and the program becomes more complex with higher performance thresholds and more rigorous, yet flawed, performance measurement methodologies that do not account for factors out of physician control, TMA foresees disastrous outcomes in our state. For example, the 2022 performance year overall performance target will be set at either the national mean or median score from a prior performance year, which may reach 70 to 90 points. This will result in a 9% payment penalty every year for thousands of Texas physician practices who continue to have to pay thousands of dollars to meet program compliance and data requirements. This is

⁷ Casalino LP, Gans D, Weber R., et al. (2016). US physician practices spend more than \$15.4 billion annually to report quality measures. Health Affairs, 35, 3. Retrieved from <https://doi.org/10.1377/hlthaff.2015.1258>

economically unsustainable for physician practices and threatens Medicare beneficiaries' access to care.

While outside the scope of the federal rulemaking process, TMA continues to advocate that MIPS and APMs under the QPP be completely voluntary and that budget neutrality in MIPS be eliminated. Instead, financial incentives in MIPS should come from supplemental funds that do not come from Medicare Part B payment cuts to physicians and other clinicians. These reforms are necessary to preserve patient access, protect physicians in small and rural practices, provide an appropriate return on the significant investments many physicians of all practice sizes have made to date, support physicians' overall practice and care delivery infrastructure, and facilitate the momentum to transition physicians to value-based care and APMs in general.

Recommendation: TMA urges CMS to streamline and simplify all compliance, documentation, and reporting requirements, as well as develop a no- to low-cost QPP data collection and reporting system.

Lack of Appropriate Adjustments and Adequate Risk Adjustment

TMA analysis shows that many of the MIPS clinical quality and cost metrics are not in physician control. Factors not in physician control often are not evenly distributed in the population, resulting in physicians being penalized if they serve disproportionate numbers of disadvantaged or high-risk patient populations. For example, according to the report on Accounting for Social Risk Factors in Medicare Payment by the National Academies of Sciences, Engineering and Medicine (NASEM) and U.S. Office of the Assistant Secretary for Planning and Evaluation (ASPE), "when social risk factors are not accounted for in performance measurement and payment in the health care system, achieving good outcomes may be more difficult for providers disproportionately serving socially at-risk populations."⁸

MACRA requires that CMS, based on individuals' health status and other risk factors, assess and implement appropriate adjustments.

Specifically, the law states that the Secretary "shall, on an ongoing basis:

- (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.

However, as we enter the fourth year of MACRA implementation, the agency has yet to propose any methodology for properly risk adjusting MIPS cost and quality measures. CMS offers a few bonus points to small practices and those who care for complex patients as a proxy and short-term solution. While we appreciate these bonuses, they are not adequate substitutes for methodologies that could make measures fair for everyone.

⁸ National Academies of Sciences, Engineering, and Medicine. (2017). Accounting for social risk factors in Medicare payment. Washington, DC: The National Academies Press. <http://nationalacademies.org/hmd/Reports/2017/accounting-for-social-risk-factors-in-medicare-payment-5.aspx>

TMA acknowledges that CMS continues to work with ASPE and other stakeholders to identify a long-term policy solution and that the agency is awaiting a second report from ASPE in October 2019 on accounting for risk factors in Medicare. Nonetheless, physicians are currently adversely affected by the lack of appropriate adjustments as required by statute. This lack of compliance with congressional intent results in flawed performance measurement methodologies, inadequate and unfair scoring policies, lower performance scores for many physicians, and tarnished physician reputations via data publicly reported on Medicare's Physician Compare website. Most concerning, these issues may have the unintended consequence of physicians deciding not to treat certain patients and not to locate their practices in areas where poverty or other specific characteristics are prevalent.

Additionally, TMA notes that the difficulty of developing proper risk adjustment methodology for patient data is an added reason that we continue to oppose the all-payer data requirement for the MIPS quality category for physicians who choose to report data via registries, qualified clinical data registries, and EHR reporting methods. While risk adjustment for the Medicare population is proving to be difficult, doing so for non-Medicare populations – including uninsured patients – may be impossible.

Recommendation: TMA continues to recommend that unless CMS can eliminate measures that are impacted by socioeconomic variables or social determinants of health, CMS must act immediately to implement statutorily required risk adjustment for both cost and quality measures. If this is not possible, the program should be completely voluntary.

Measures Not in Physician Control and Penalties for Serving Specific Patient Groups

Many of the measures used to assess quality and cost depend very much on whether patients choose to follow physician direction or advice. In addition, many measures are also highly dependent on social determinants of health (SDOH), which influence patient actions and choices as well. According to the Centers for Disease Control and Prevention, SDOH are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.⁹ These factors are critical to performance measurement, especially for the quality and cost performance categories.

TMA reiterates that 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.¹⁰ Patient demographic variables including gender and ethnicity have been shown to be related to medication compliance;¹¹ and racial, religious, or cultural variables affect patient preferences for care including end-of-life choices about intensive care and resuscitation.¹² Furthermore, patients with a lifetime history of

⁹ CDC.gov. 2019 Social Determinants of Health: Know What Affects Health <https://www.cdc.gov/socialdeterminants/index.htm>

¹⁰ 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>

¹¹ 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.15251497.2004.30516.x>.

¹² 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>

poverty and poor access to medical care enter Medicare, through age or disability, with pent-up demand that creates high cost and poor outcomes. Cost and quality scores that are adversely affected by these variables penalize the physicians who serve disproportionate numbers of patients from certain population subgroups. 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.

In previous proposed rules, CMS acknowledged concerns from commenters that physicians in small practices or those practicing in rural areas tend to have older patient populations, as well as higher rates of poor health outcomes, comorbidities, chronic conditions, and other social risk factors, which can increase significantly the costs of providing care and services. CMS also noted that such physicians may be disproportionately more susceptible to lower scores across all performance categories and negative payments adjustments, which may further strain already limited resources and workforce shortages, and reduce access to care. These concerns are validated in the NASEM and ASPE report on Accounting for Social Risk Factors in Medicare Payment.

While health-related social needs and associated behaviors drive 70% of health outcomes, many physician practices are not equipped to address such needs nor are they oftentimes compensated for such services. According to The Physicians Foundation, there is an urgent need to account for poverty and other health-related social needs as central to any truly effective health care system.¹³ CMS should be at the forefront of establishing program policies that enable and compensate physicians not only to deliver care, but also to address the social needs of their Medicare beneficiaries. Without adequate risk adjustment, many of the existing program measures will continue to be out of physician control and penalize physicians serving disadvantaged patient populations.

Recommendation: TMA urges CMS to eliminate measures based on actions or outcomes that are not in physician control. CMS should eliminate measures that penalize physicians who disproportionately treat patients of disadvantaged populations. CMS should establish program policies that enable and compensate physicians to address social determinants of health. If this is not possible, the program should be completely voluntary.

MERIT-BASED INCENTIVE PAYMENT SYSTEM

Policy Priorities

Low Volume Threshold

In general, physicians and other clinicians must participate in MIPS, unless otherwise exempt, if they: 1) bill more than \$90,000 for Medicare Part B covered professional services, 2) see more than 200 Medicare Part B patients, and 3) provide 200 or more covered professional services to

¹³ The Physicians Foundation Viewpoints on Social Determinants of Health. (2019). <http://physiciansfoundation.org/wp-content/uploads/2017/03/The-Physicians-Foundation-SDOH-Viewpoints.pdf>

Medicare Part patients. Physicians and other clinicians may elect to opt in or voluntarily report if they meet certain criteria, or not report at all.

TMA is very pleased to see that no changes, such as reducing or eliminating the low volume threshold, were proposed. A reduction in criteria would require more physicians to participate in MIPS, which TMA believes would have disastrous consequences for small and rural practices in Texas and across the country.^{14,15,16}

MIPS generally threatens the financial viability of physician practices and patient access. Flawed program policies and lack of statutorily-required appropriate risk adjustment remain. The program has proven to be harmful to small and rural practices. For many practices, program compliance and the cost of reporting far exceeds any possible benefit from incentives earned or penalties avoided. Changes to the low volume threshold criteria could help ameliorate all of these problems.

Recommendation: TMA urges HHS and CMS to increase the low-volume threshold for the 2020 QPP and beyond for all physicians, and to exempt small practices from required participation in MIPS but continue to offer them the opportunity to opt in or voluntarily report.

MIPS Performance Period

In the 2019 QPP final rule, the agency finalized 12-month performance periods for the 2020 and 2021 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 promoting interoperability (PI) and improvement activities categories. Given that these policies were finalized last year for the next two years of the program, the agency proposes no new changes.

In the summer of 2018 when the 2019 QPP proposed rule was published, the agency had not yet published the experience report for the first year of program implementation. Now that we have data to make an informed decision based on program evidence, TMA points out that Tables 8 and 9 in the 2017 QPP experience report show that not all MIPS-eligible clinicians were able to report data for a full 12 months in 2017 for the quality category. In fact, of the 906,093 MIPS-eligible clinicians who submitted data as shown in Table 8, a total of 130,535 clinicians in small and rural practices reported data on quality measures for less than 12 months. Moreover, we know that 4.7% or 42,586 of MIPS-eligible clinicians who reported at the individual reporting level, reported data on quality measures using the claims-based reporting method, which has a high error rate including failing to report data for a full 12 months. It is fair to state that the 2020 and 2021 performance periods will likely result in many practices failing their quality reporting, receiving lower performance scores, and/or falling below the overall performance threshold and ending up with a payment penalty.

¹⁴ U.S. Government Accountability Office. (2016). Medicare value-based payment models: Participation challenges and available assistance for small and rural practices. www.gao.gov/assets/690/681541.pdf

¹⁵ U.S. Government Accountability Office. Small and Rural Practices' Experiences in Previous Program and Expected Performance in the Merit-Based Incentive Payment System. (2018). <https://www.gao.gov/assets/700/692179.pdf>

¹⁶ Mendel P, Buttorff C, Chen PG, Sieck K, Orr P, Qureshi NS, Hussey PS. (2019). Perspectives of Physicians in Small Rural Practices on the Medicare Quality Payment Program. Santa Monica, CA: RAND Corporation. Retrieved from www.rand.org/pubs/research_reports/RR2882.html

Furthermore, other than general 2018 QPP participation rates published in July, the agency did not provide any data within the 2020 proposal rule or elsewhere that demonstrate that all practices, including small and rural practices, were able to meet the 12-month data requirement for the quality category in 2018. The 2018 QPP performance year was the year that all MIPS-eligible clinicians were supposed to transition to the 2015 edition of certified EHR technology (CEHRT). There is no data that show whether the required upgrade caused practice disruption and hindered meeting the 12-month data collection and reporting requirements, especially for practices that use their EHR for quality reporting.

Recommendation: TMA urges CMS to refrain from finalizing policies prematurely and before providing and evaluating program data that support such changes. To reduce harm to physicians, the agency should allow physicians to determine their own MIPS performance period, from 90 days up to a full calendar year, until data demonstrate that reporting for a full 12-month performance period is achievable by physicians in all practice sizes and across all reporting methods.

MIPS Performance Threshold and Additional Performance Threshold for Exceptional Performance

CMS proposes a performance threshold of 45 points for the 2020 performance year and 60 points for the 2021 performance year, up from 30 points in 2019, 15 in 2018, and 3 in 2017. CMS also proposes to increase the additional performance threshold for exceptional performance to 80 points in 2020 and 85 points in 2021, up from 75 points in 2019, and 70 in 2018 and 2017.

Proposed MIPS Performance Thresholds			
MIPS Performance Targets 0-100 point scale	2020 Performance Year 2022 Payment Year	2021 Performance Year 2023 Payment Year	2022 Performance Year 2024 Payment Year
Target to avoid the 9% penalty and earn an incentive payment	45 points	60 points	Mean or median score from a prior performance year (potential value between 70-90 points)
Target to earn an incentive payment plus and additional bonus for exceptional performance	80 points	85 points	TBD

CMS reports that these values would provide for a gradual and incremental transition toward a performance threshold that must be set at the mean or median final score for a prior period for the 2022 performance year. However, we remind CMS that in 2017, physicians in solo and small group practices scored, on average, a total of only 43 points, whereas large practices and those who participated in MIPS APMs, scored, on average, 74 points and 87 points respectively. TMA believes that an increase in the overall MIPS performance thresholds would make it even more challenging for many Texas physicians to avoid the 9% payment penalty.

2017 MIPS Mean and Median Final Scores (0-100 point scale)						
Practice Designation	Small Practices (1-15 clinicians)	Small and Rural Practices	Rural Practices	Large Practices (16 or more clinicians)	MIPS APMs (e.g. ACOs)	2017 MIPS Overall National Total
Mean	43.46	44.66	63.08	74.37	87.64	74.01
Median	37.37	42.00	75.29	90.29	91.76	88.97

TMA further believes that an increase of more than 5 points (up to 35 points) to the threshold in 2020 would be premature. For example, CMS has not yet published average performance score across all practices for the 2018 QPP performance year. The association believes that increasing the thresholds would only exacerbate ongoing disparities and harm small and rural practices again as they did in 2017. Moreover, because CMS has implemented policies that favor large group practices and MIPS APM participants over solo and small group practices, the agency should revise policies so they support a fair and ethical program for all physicians and gather data on various practice types’ capabilities of reaching new performance thresholds.

Recommendation: For the 2020 performance year, TMA recommends an increase of no more than 5 points for the performance threshold, which would result in a maximum of 35 points. The additional performance threshold for exceptional performance should remain at 75 points.

MIPS Category Weights and Contributions to Final Score

Currently, the MIPS final score is calculated as 45% for the quality category, 15% for cost, 25% for promoting interoperability, and 15% for improvement activities. We understand that these weights are default weights and can be adjusted in certain circumstances, such as for MIPS APMs or hardship exceptions. Due to the technical amendments made to MACRA by the Bipartisan Budget Act of 2018 (BBA), current law requires a contribution “not less than 10% and not more than 30%” for the cost category through 2022. By law, with every percentage increase made to the cost category, the quality category will decrease until each contributes 30% to the final score.

CMS proposes to increase the cost category weight to 20% and decrease the quality category weight to 40% in 2020. For the 2021 and 2022 performance years, the agency also proposes incremental increases and decreases by 5% until both categories are weighted at 30% each. As required by law, the weights for the promoting interoperability and improvement activities categories would remain the same.

Proposed MIPS Performance Category Weights			
MIPS Category	2020 Performance Year 2022 Payment Year	2021 Performance Year 2023 Payment Year	2022 Performance Year 2024 Payment Year
Quality	40%	35%	30%
Cost	20%	25%	30%
Promoting Interoperability	25%	25%	25%
Improvement Activities	15%	15%	15%

While TMA acknowledges that MACRA and the BBA require that the cost and quality categories be weighted at 30% each in 2022, the association believes it is premature to increase the cost category in 2020 given the lack of cost performance data that CMS has yet to provide to support an increase. Although the cost category weight was weighted at zero in 2017, CMS had previously stated it would provide performance feedback on cost measures to physicians as informational data for the first year of program implementation. While the cost performance did not count in 2017, the agency did not provide overall cost performance results for all practices in

the 2017 QPP experience report, which would help to inform our comments moving forward. TMA believes physicians need more time to familiarize themselves with the new cost measures and evaluate their cost performance data to identify areas for improvement so they have a fair shot at “performing” well as cost category weights increase.

In addition, many problems continue to surround the cost category, such as lack of adequate risk adjustment methodologies, flawed total per-capita cost and Medicare spending per-beneficiary measures even with the proposed changes to attribution rules, and newly implemented episode-based cost measures that have yet to be proven to be fair across all applicable physicians. TMA strongly opposes an increase beyond the current 15% weight until improvements are made.

Recommendation: Until cost performance data are published and evaluated for all cost and episode-based measures, and overall improvements are made to the cost category, TMA urges CMS to make no changes to the MIPS category weights: 45% for the quality category, 15% for the cost category, 25% for the promoting interoperability category, and 15% for the improvement activities category.

Quality Performance Category

Data Completeness Criteria

For the 2020 performance year, CMS proposes to increase the data completeness threshold to 70% for the quality category, up from 60% in 2019, and 50% in 2018 and 2017. The increased threshold would apply to data submitted on quality measures via the following collection types: qualified clinical data registry (QCDR) measures, MIPS clinical quality measures (CQMs), electronic CQMs (eCQMs), and Medicare Part B claims measures. CMS does not propose any changes to the data completeness criteria for physician who choose to report data on CMS Web Interface and CAHPS for MIPS survey measures.

CMS reports that it believes it is important to incorporate higher data completeness thresholds over time to ensure a more accurate assessment of a MIPS-eligible clinician’s performance on quality measures. The agency also implies that increasing the threshold would deter “cherry picking.” However, as acknowledged in the proposed rule, TMA believes the agency should be cautious in accelerating the data completeness thresholds, because this increase may jeopardize physicians’ ability to participate and perform well under MIPS.

The agency reports it has based its analysis of data completeness rates from data submission for the 2017 MIPS performance period. In 2017, the average data completeness rate was 76% for clinicians who reported at the individual reporting level, 74% for small practices, and 85% for groups. TMA assumes that “group” means large group practices, but the agency does not label the data as such (Table 35). CMS thus believes that it is feasible for eligible clinicians and groups to achieve a higher data completeness threshold.

This particular policy is very important to TMA because 73% of Texas physicians are in small practices of eight or fewer clinicians per our 2018 Survey of Texas Physicians and also because

the association advocates for physicians in all practice sizes. CMS data show that the 2017 MIPS data completeness averages ranged between 74-85% across all practice sizes. Before adopting a higher data completeness threshold, TMA would like to ensure that 100% of physicians have the ability to achieve a higher threshold across all reporting methods without further burdening them and instilling fear of failure or penalty.

TMA believes the higher threshold would result in either lower scores for small practices or failed reporting for large practices due to the three-point floor policy. CMS should not propose increasing the degree of difficulty in achieving data completeness at the same time it proposes to change the floor for scoring quality measures that do not meet data completeness requirements for large group practices. Increasing the threshold would result in large group practices receiving a score of zero points for each measure that does not achieve 70%. In some instance, this would result in poor performance scores, potential payment penalties, and no return on investment for reporting costs.

Furthermore, reporting on an additional 10% of data without committing errors is unrealistic for many physician practices, especially those that report data on quality measures by claims or the manual data entry process for registries. Also, because CMS publishes the measure specifications only days before the start of the performance year, physicians reporting by claims or MIPS-related vendors oftentimes are unable to make the necessary updates until after the performance year has begun. An increase to 70% may adversely affect practices across all reporting methods. Moreover, many groups have several practice sites that use different data systems, which makes data collection across the entire group very challenging. Especially given that the agency is proposing to clarify that “if quality data are submitted selectively such that data are unrepresentative of a MIPS-eligible clinician or group’s performance, any such data would not be true, accurate, or complete.” An increase to 70% would result in failed audits for groups that are unable to capture the additional 10% data across all practice sites. Additionally, increasing the data completeness threshold would result in increased administrative and cost burdens for physician practices which is contrary to CMS’ Patients Over Paperwork Initiative.

TMA asserts that CMS is basing its proposal on incomplete data rather than taking into consideration the unique differences in practice sizes, such as evaluating reporting threshold averages by reporting method/collection type AND practice size. While the data completeness threshold averages may have ranged between 74-85%, CMS does not provide the breakdown of averages by reporting method/collection type AND practice size. Furthermore, given the “pick your pace” polices in 2017 when many practices reported on fewer than six measures, CMS does not state whether the 74-85% averages demonstrate the ability across all practices to achieve such rates for the full six-measure requirement.

Lastly, we remind CMS that effectively designed MIPS audits would identify cherry picking. TMA believes that all physicians should not be penalized and face unrealistic data completeness thresholds because of the actions of a few vendors and practices.

Recommendation: To prevent jeopardizing physicians’ ability to perform well in the MIPS quality performance category, and until sufficient data are provided to support an increase, TMA urges CMS to keep the data completeness threshold requirement at 60%.

Removal of Measures

Currently, CMS offers a total of 268 MIPS quality measures for the quality category. For the 2020 performance year, the agency proposes to remove 55 measures (21% of the total). CMS states that quality measures may be considered for removal if the HHS secretary determines that they are no longer meaningful or do not align with CMS' Meaningful Measures Initiative, among other criteria. The agency further states that it believes its proposal to remove 55 quality measures will lead to a more parsimonious inventory of meaningful and robust measures in the program.

TMA asserts that MIPS quality measures that may no longer be meaningful to HHS and CMS may still be very much meaningful to physicians, their practices, and their patients. 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 have a limited number of applicable measures and measure types for their preferred data submission mechanism and do not have the opportunity to report on six measures and/or additional outcome or high-priority measures for bonus points. In addition, while cross-cutting quality measures are included in measure sets to offset the limited number of measures by specialty, physicians report that cross-cutting quality measures are the least meaningful to report.

TMA reiterates that the lack of an adequate number of quality measures and measure types across all data submission mechanisms is a major flaw of the QPP. Many physicians view the existing quality measures as failing to capture accurately the quality of their practice and specialty as a whole. The lack of a sufficient number of meaningful and applicable quality measures for all physicians may result in physicians collecting data on meaningless measures just to avoid the penalty. TMA believes this would be contrary to MACRA and clinical quality improvement in general.

As we enter the fourth year of program implementation, the ongoing issue of a poor quality measures portfolio for the MIPS program demonstrates the agency's failure to meet the aims of MACRA and Congress. Having an adequate MIPS quality measures portfolio that includes parity among measures and measure types for all physicians and across all reporting methods is fundamental to the QPP. Without it, CMS has no program that provides fair and equitable program incentives for all physicians. The burden of proof should rest on CMS to demonstrate that removing so many quality measures during the early years of program implementation will not adversely affect physicians in the process.

Recommendation: TMA recommends against removing 55 MIPS quality measures from the current list of 268 MIPS quality measures for the 2020 performance year unless they are out of physician control, penalize physicians who disproportionately treat patients of disadvantaged populations, or are impacted by socioeconomic variables or social determinants of health. TMA further urges the agency to provide the breakdown for each specialty and by data collection type that demonstrates that physicians would not adversely be affected by the removal of so many measures.

Removal of Measures That Do Not Meet Certain Criteria After Two Consecutive Years

CMS proposes to remove MIPS quality measures that do not meet case minimum and reporting volumes required for benchmarking after being in the program for two consecutive performance periods. The agency reports it has observed instances where MIPS quality measures have had low reporting rates year over year, which has made it difficult for those measures to achieve a benchmark. As a result, physicians and other clinicians have received no more than three points for each measure that is unable to meet benchmarking criteria.

TMA disagrees with removing any quality measure after only two consecutive performance years and believes that establishing a two-year timeframe is arbitrary. The association reminds CMS that the “pick your pace” policies that were in place in 2017 allowed physicians to report on fewer than the six-measure requirement. Similarly, the increase to the low volume threshold policy in 2018 exempted more clinicians from MIPS participation. These two factors may have prevented the uptake for reporting on certain quality measures during the first two years of program implementation.

Many physician practices prefer to submit data on quality measures via one collection type and oftentimes are limited to only the measures reportable by their chosen reporting method, which impacts utilization rates for other quality measures. In addition, while we acknowledge that quality measures need to meet case minimums and have certain reporting volumes required for benchmarking, TMA believes CMS’ own scoring policies create this issue in the first place. For example, because quality measures without benchmarks are only assigned three points, physicians steer away from such measures because the agency has a designed a program that incentivizes physician to seek quality measures that would result in the most MIPS points rather than encourage the selection of quality measures that are most meaningful to physicians, including new quality measures that have no benchmarks.

As CMS proposes to transition physicians from regular MIPS to an MVP framework, removing measures would result in very few measures available for the creation of MVPs. Many physicians prefer to report the same measures annually to reduce burden and maximize scoring, especially for measures for which they have demonstrated high performance. Furthermore, quality measure development is a multi-million dollar and multi-year endeavor and it would be reasonable to conclude that new measures take more than two years to gain traction and demonstrate meaningful measurement.

Recommendation: TMA urges CMS to refrain from removing MIPS quality measures that do not meet case minimum and reporting volumes required for benchmarking after being in the program for two consecutive performance periods.

Required Number of Measures Physicians Must Report

For the 2020 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 submit data on at least six quality 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.

Although provisions in MACRA direct the HHS secretary to emphasize outcome measures under the quality category, the law does not *require* physicians to report data on outcome measures. Because CMS has chosen to make outcome measures a requirement despite the limited number of outcome measures available (with the majority reportable only through registry), we continue to believe this policy is unfair and complicates the data submission criteria for many physicians.

For the 2019 performance year, the program offers 268 MIPS quality measures. Although this number may appear sufficient, the list of quality measures decreases significantly to just a few when narrowed by data collection type/reporting method, specialty area, applicable measure per physician, and measure type. Among the 268, 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. Exacerbating this issue is CMS' proposal to remove 55 MIPS quality measures in 2020 as well as those measures that do not meet case minimums and reporting volumes for benchmarking after two consecutive years.

While the agency now allows physicians to submit data on quality measures using more than one data collection type, TMA does not believe that this option should be viewed as a solution to our concerns. Although this policy offers more flexibility, it increases administrative and cost burdens associated with the quality category. It does not solve the problem of insufficient meaningful and applicable measures for all physicians per preferred data collection type.

TMA acknowledges that the list of QCDR measures is different from the list of MIPS quality measures and offers additional measures to report. However, that list shrinks 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.

TMA continues to be concerned that the quality measure portfolio for the MIPS program does not support physicians' ability to succeed in the QPP, which results in an inequitable assessment of quality performance due to a lack of parity among measures and measure types for all physicians and across all data collection types. Therefore, TMA again recommends decreasing the number of measures physicians must report for the MIPS quality category. Decreasing the number of measures in 2020 also would help to inform CMS which measure configurations are meaningful to physicians in preparation for bundling pre-defined measure sets for the agency's future MVPs.

TMA further 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, 2018, and 2019, 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, TMA urges CMS to support physician choice and require data only for the measures physicians find meaningful to their patients, practice, and specialty.

Recommendation: Due to a poor MIPS quality measure portfolio that lacks a sufficient number of meaningful measures and measures types for all physicians and reporting methods, 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 those physicians who do not have sufficient measures to earn bonus points for the MIPS quality category.

All-Payer Data Requirement

For the MIPS quality category, 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 require only 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 required use of all-payer data to assess physicians' performance on quality measures and determine Medicare Part B payment bonuses and penalties. TMA feels strongly that quality performance and Medicare Part B payment bonuses and penalties should not be based on clinical data representing non-Medicare beneficiaries for several reasons:

- 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 does not explicitly state all-payer data or non-Medicare beneficiary and is permissive on this subject, TMA recommends against the use of all-payer data.
- Medicare and other payers have very different patient populations; medical policies; billing requirements; payment for services, procedures, and preventative care; and care coordination efforts. 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 more commercially insured patients over those who have a high volume of Medicare or Medicaid beneficiaries or serve disadvantaged populations, included high rates of uninsured patients.
- 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. While risk adjustment for the Medicare population is proving to be difficult, doing so for non-Medicare populations may be impossible, including the uninsured. TMA feels strongly that physicians and groups should not be rewarded or penalized based on variations in payer mix and patient populations.

- A Medicare value-based payment system that requires some physicians to report a portion of the data to represent all-payers, including the uninsured, and other physicians to report only Medicare Part B data, is a flawed program policy. Furthermore, this requirement continues to contribute to undue administrative burden by increasing significantly the documentation and volume of data physicians must report per measure and makes it more difficult to meet the proposed 70% threshold requirements for each data collection type. 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.

Furthermore, TMA urges CMS to include in its annual QPP experience report the difference between final scores and payment adjustment outcomes for physicians who strictly submitted Medicare Part B data and those who submitted all-payer data. This data was missing in the 2017 QPP experience report and would have helped TMA and others determine whether the agency's policies support a fair program across all physicians and data collection methods.

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 for 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

In general, quality measures that can be scored based on performance, have a benchmark, have at least 20 cases, and meet the data completeness threshold are assigned 3-10 points based on performance compared to the benchmark. For the 2020 MIPS performance year, CMS proposes to apply special scoring policies for quality measures that meet the proposed 70% data completeness threshold requirement but do not have a benchmark or meet the case minimum requirement that would result in three points for the measure.

However, CMS proposes to assign zero points for quality measures that do not meet the proposed 70% data completeness threshold for groups with more than 15 clinicians, even if they have a measure benchmark and/or meet case minimum. Small practices with 15 or fewer clinicians would continue to receive three points for those quality measures.

TMA appreciates the efforts made by the agency to create favorable scoring for small practices. However, the association strongly opposes the policy proposal that would assign zero points in 2020 or future years for any measure that does not meet data completeness criteria. We feel granting partial credit offers some reward for physicians who undertake costly reporting efforts. It also creates some incentive to report.

Recommendation: To support fair scoring and incentivize reporting, CMS should maintain the minimum three-point floor for physicians in all practice sizes, including for those who do not meet data completeness criteria.

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. Currently, the survey contains 10 summary survey measures that include a total of 54 questions in yes or no and multiple-choice format to assess the following:

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

The CAHPS for MIPS survey collects patient experience data from Medicare Part B patients only, is administered on paper and phone based methods, and survey scores are publicly reported on the Physician Compare website. The survey has been optional for the MIPS quality performance category for groups with two or more clinicians since 2017. For physicians who choose to conduct the survey, 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.

TMA is pleased that CMS did not propose any new or revised data submission criteria for the CAHPS for MIPS survey and that the survey will remain optional for the 2020 performance year (for non-ACO participants in MIPS). Given that the 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 for future years of the program as well. Additionally, we would oppose expanding the CAHPS for MIPS survey to individual clinicians (even if a new instrument was developed) without sufficient evidence that the survey instrument is scientifically valid, fair across all physician practices, improves quality of care, and physicians are reimbursed for any added administrative costs incurred as a result of collecting and reporting survey data.

CMS stated in the 2019 QPP proposed rule that costs to contract with a CMS-approved CAHPS vendor range from approximately \$4,000 to \$7,000, depending on services requested, per group practice, per performance year. The agency did not include any data in the 2017 QPP experience report showing how many physician practices elected to report CAHPS for MIPS survey data in the first year of program implementation. If the CAHPS survey was meaningful to physicians and associated costs were deemed affordable, utilization rates would be very high.

Recommendation: TMA recommends that the CAHPS for MIPS survey remain strictly voluntary for the 2020 MIPS performance year and for future years of the program and that the survey should not be expanded to individual clinicians. TMA urges CMS to publish 2017, 2018, and 2019 national and state data for the CAHPS for MIPS survey so all stakeholders can evaluate its utilization rates.

Adding Patient Ratings and Narratives to the CAHPS for MIPS Survey

CMS seeks comment on adding an additional question to the survey to capture the patient voice by asking patients to rate their overall experience and satisfaction with a recent health care encounter. CMS also seeks comment on adding open-ended questions to the survey inviting patients to respond to a series of questions in free text. The new questions could potentially be added to the calculation of the overall survey score and CMS would publically report patients' ratings and narratives on the Physician Compare website because the agency states the information would be highly valued by patients and their caregivers as they evaluate their health care options in Medicare.

TMA is very concerned about this proposal because CMS has not yet implemented statutorily required adequate risk adjustments to cost and quality measures, which has resulted in flawed performance measurement methodologies, inadequate and unfair scoring policies, lower performance scores for many physicians, and tarnished physician reputations via data publicly reported on Physician Compare. Adding subjective patient ratings and narrative reviews to physician profiles on Physician Compare, which oftentimes have nothing to do with the quality of care patients receive, would further exacerbate the program's problems.

Without a full description of the evidence-based tool and methodologies CMS would use to factor these new survey components into the calculation of the survey score and sound evidence that such data improve quality of care and are fair across all practices, TMA believes that the agency is off base in its desire to include them as part of the CAHPS for MIPS survey, especially as a means to assess physician performance to determine MIPS payment adjustments.

Recommendation: TMA recommends against including patient ratings and narrative reviews as part of the CAHPS for MIPS survey, tying subjective ratings and reviews to physician payment, or publishing such data on physician profiles on the Physician Compare website.

Global and Population Health Measures

For the 2021 performance year, CMS proposes to include a new population health measure for the quality category. Data for the All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions (MCC) measure would be captured through administrative claims data. CMS reports that this is a risk-adjusted administrative claims measure to assess Medicare beneficiaries aged 65 or over who have two or more of nine chronic conditions.

TMA appreciates that the MCC measure would be risk adjusted and that no additional reporting would be necessary, but believes this particular measure would not be appropriate for MIPS. We are concerned that the MCC measure is not scientifically sound to assess individual and group performance within the context of the MIPS program, is not fair to all physicians, and that the attribution methodology used for this measure may hold physicians accountable for admissions for which they had no opportunity to intervene and prevent or for admissions completely unrelated to the services they provide to the patient.

Many physicians offer same-day appointments, extended office hours, 24/7 access to care, chronic care and transitional care management, and telehealth services; they instruct their patients to notify them and their care team for any needs or changes in condition. However, many patients with MCCs end up with unplanned admissions without ever having contacted their physician or care team beforehand. The MCC measure in many instances would be out of physicians' control.

Lastly, while MACRA states that the HHS secretary may use global measures, such as global outcome measures and population-based measures, the law does not require that CMS use global measures in MIPS.

Recommendation: TMA strongly believes CMS should use only measures in the MIPS quality category that are within physician's control and recommends against using the MCC measure for the MIPS quality category in 2021 or future years.

Topped Out Measures

Quality measures identified as extremely "topped out" are considered to have high, unvarying performance where no meaningful room for improvement can be identified. CMS previously determined that once a quality measure has reached extremely topped out status, the agency may propose removing the quality measure in the next rulemaking cycle, regardless of whether it is in the midst of the topped out measure lifecycle.

However, CMS said the agency would consider retaining the measure if there are compelling reasons as to why it should not be removed, such as resulting in an insufficient number of quality measures for a specialty or if the measure addressed an area of importance to the agency. CMS seeks comment on whether it should increase the data completeness threshold for quality measures that are identified as extremely topped out, but are retained in the program due to the limited availability of quality measures for a specific specialty.

Because physicians have no control over the number of available quality measures for the MIPS quality category, TMA strongly opposes increasing the data completeness threshold for extremely topped out measures that are retained due to an insufficient number of quality measure for certain specialty measure sets. Increasing the data completeness threshold would increase physician burden and not be fair to the affected physicians.

Recommendation: CMS should not increase the data completeness threshold for extremely topped out measures that are retained in the program due to an insufficient number of quality measure for certain specialty measure sets. TMA urges CMS to prioritize measure development for known measure gaps to improve its quality measure portfolio. Furthermore, if CMS cannot ensure a robust list of quality measures for certain specialties, the affected physicians should have the option to be exempt from MIPS participation or have their quality category reweighted until a sufficient number of new measures is available.

Cost Performance Category

Episode-Based Measures

For the 2020 performance year, CMS proposes significant changes to the cost category, including adding 10 newly developed episode-based cost measures and revising the existing total per capita cost and Medicare spending per beneficiary measures. CMS reports episode-based measures were developed to represent cost to Medicare and beneficiaries for items and services furnished during an episode of care. Episode-based measures are developed to compare clinicians on the basis of the cost of the care clinically related to their initial treatment of a patient and provided during the episode's timeframe. Because of the limited number of episode-based measures, they apply only to a subset of physicians.

While CMS continues to implement newly developed episode-measures and develop coding methodologies intended to aid in appropriate attribution for cost measurement, TMA reiterates that the agency should keep the cost category weight as low as possible. The association believes physicians need more time to familiarize themselves with the new episode-based cost measures, learn about the new patient relationship category codes, and evaluate their data to identify areas for improvement so they have a fair shot at "performing" well in the cost category.

TMA is awaiting publication of the cost category's performance results within the context of the MIPS program rather than just field testing data to inform our comments moving forward. After full data is available, we urge CMS to evaluate the new measures to determine whether they are properly risk adjusted, are truly within physicians' control, and treat physicians with disadvantaged populations fairly. Without adequate adjustments to eliminate the known effects of various socioeconomic factors or social determinants of health, TMA remains concerned that newly implemented episode-based measures for the cost category may result in unfair scoring among specialists and lower performance scores and/or result in payment penalties for the applicable physicians compared to other physicians who have no episode-based measures available to them.

Recommendation: To inform our comments moving forward, TMA urges CMS to publish overall performance results for each measure across all practices for the cost category weight. TMA further urges CMS to provide data on whether all episode-based measures are truly within physicians' control and adequately risk adjusted.

Proposed Revisions to the Operational List of Care Episode and Patient Condition Groups and Codes

MACRA required the development of patient relationship category (PRC) codes to define and distinguish a physician's relationship to and responsibilities for a patient at the point of furnishing an item or service. At this time, reporting PRC codes on Medicare claims is voluntary, and the agency advises physicians to gain familiarity with the PRC codes to help inform CMS about their future use in cost measure attribution methodology. PRC codes are modifiers reported on claims, do not affect Medicare payment, and do not impact beneficiaries.

For the 2020 year, CMS proposes to revise the operational list to include 10 new care episode and patient condition groups and codes, which will serve as the basis for the 10 new episode-based measures that CMS proposes for the cost category. Furthermore, the agency proposes to add this voluntary activity as a new improvement activity to the inventory next year. Physicians who report the modifiers on 50% or more of Medicare claims for a continuous 90-day period would earn points for a high-weighted activity. While TMA believes mandating the submission of PRC codes would increase physician burden, we acknowledge the agency's efforts to develop appropriate attribution methodology in cost measurement and support providing improvement activity credit to physicians who voluntarily report PRC codes.

Recommendation: TMA supports providing improvement activity credit to physicians who voluntarily report PRC codes. TMA urges CMS to increase its outreach and education on proper coding and submission of PRC codes.

Total Per Capita Cost and Medicare Spending Per Beneficiary Measures

CMS reports the agency previously finalized the total per capita cost and Medicare spending per beneficiary measures for MIPS as an important measurement of clinician cost performance and continues to believe the measures are appropriate for the program. During CMS' routine measure maintenance, the agency re-evaluated both measures based on the feedback it has received to date about the concerns and issues surrounding each measure which is summarized below.

Total per capita cost measure:

- The total per capita cost measure's attribution methodology assigned costs to clinicians over which the clinician has no influence, such as costs occurring before the start of the clinician-patient relationship;
- The attribution methodology did not effectively identify primary care relationships between a patient and a clinician and could potentially attribute beneficiaries to a clinician not responsible for the beneficiaries' primary care;
- The measure did not account for the shared accountability of clinicians and that attributing costs to a single clinician or clinician group could cause fragmentation of care; and
- The beneficiary risk factors were determined one year prior to the start of the performance period, which would preclude the risk adjustment methodology from reflecting the more expensive treatment resulting from comorbidities and/or complications that might arise during the performance period.

Medicare spending per beneficiary measure:

- The attribution methodology did not recognize the team-based nature of inpatient care;
- The attribution based on the plurality of Part B service costs during index admission could potentially attribute episodes to specialties providing expensive services as opposed to those providing the overall care management for the patient; and

- The measure captured costs for services that are unlikely to be influenced by the clinician's care decisions.

Based on this feedback, CMS proposes to revise methodologies and will continue to score physicians on both measures for the cost category. TMA asserts that the fact that CMS moved forward with proposed changes to current methodologies is an acknowledgement that both measures were highly flawed for the 2017, 2018, and 2019 performance years and validates our longstanding concerns that these measures are not appropriate for MIPS. While TMA appreciates the agency's efforts to improve the measures, we believe the proposed revised methodologies, particularly attribution and risk adjustment, remain an issue. TMA further believes that in spite of the proposed revisions, these measures would continue to hold physicians accountable for patients' medical conditions that are managed outside of their purview and for costs over which they have no control, including drug prices.

We agree that measuring cost is an integral part of value measurement, but it is useful as a comparison tool only if the underlying component parts are fair and meaningful. While these measures may be useful for some purposes, we continue to believe they are misleading and harmful as measures of physician performance in MIPS. The attribution rules used in calculating these measures will continue to cause physicians to be rated based on costs of services that are completely unrelated to any medical care the physician provided, ordered, or recommended. For example, using these measures, physicians will continue to be 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 possibly that are services they specifically advised against.

Recommendation: TMA strongly urges CMS to remove the total per capita cost and Medicare spending per beneficiary measures from MIPS. The cost category should only include measures that are in physician control, adequately risk adjusted, use appropriate attribution, treat physicians who care for patients in disadvantaged populations fairly, and actually improve value.

Improvement Activities Performance Category

Improvement Activities Inventory

Of all the MIPS requirements, the improvement activities category may be the only one that is completely within physicians' control because they can choose which activities to participate in and complete them over any 90-day period within the performance year, using their own time and efforts. We are pleased that CMS will continue to allow physicians to report improvement activities through as many collection types as necessary in a manner that best accommodates their practice, including simple attestation. We are also pleased that the agency will maintain its special scoring policies for practices with special status designations.

For the 2020 performance year, CMS proposes to remove 15 improvement activities because the activities are "duplicative" of other activities, modify seven activities, and add two new ones.

TMA appreciates the agency's inclusion of a broad range of activities, but disagrees with removing any improvement activity from the list. We believe many practices have made financial investments to perform activities, and no activities should be removed from the list unless they are obsolete, such as activities that require participating in a program that no longer exists. Furthermore, we caution CMS from removing too many "duplicative" improvement activities from the list without ensuring that the corresponding remaining activity does not require physicians to perform more work than in the "duplicative" one.

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 activities. Additionally, TMA reiterates the importance of updating the QPP website with the most current list of improvement activities immediately after the final rule is published so physicians are informed in advance of the performance year that their improvement activity no longer exists or has been modified.

Recommendation: To foster program consistency and reduce physician burden, CMS should make no changes to the improvement activities category other than to amend or add additional activities to the inventory. To support practice readiness, CMS should update the QPP website with the most current list of improvement activities immediately after the final rule is published.

Improvement Activities for Group Reporting

Currently, all MIPS-eligible clinicians reporting as a group receive the same improvement activities performance category score if at least one clinician within the group performed an improvement activity for a continuous 90 days in the performance period. However, beginning with the 2020 performance year, CMS proposes to increase the group reporting threshold from at least one clinician to at least 50% of the group, and at least 50% of a group's National Provider Identifiers NPIs must perform the same activity for the same continuous 90 days.

CMS reports that it believes a 50% threshold is achievable and appropriate because, if a group has implemented an improvement activity, the activity should be recognized and adopted throughout much of the practice in order to improve clinical practice, care delivery, and outcomes. The agency reports that this rationale aligns with its definition of an improvement activity. However, we disagree that the proposed 50% requirement would align with the definition, as MACRA does not specify the percentage of clinicians who must perform an activity.

TMA opposes the two proposals and believes the changes would increase complexity and physician burden for group practices. While there are over 100 improvement activities to choose from, we believe the number of activities decreases significantly when narrowed by what is actually meaningful and applicable to each group, especially for specialty and multi-specialty groups. Requiring at least 50% of individual clinicians in a group to perform the same activity and within the same continuous 90-day time period, and in many instances across several practice sites, would result in many groups selecting activities that simply apply to half of the group rather than select the activities that are most meaningful to each individual physician's

respective patient panel within the group. The association believes it should be left to the discretion of each group to determine the improvement activities, the percentage of physicians who perform the activities, the time period for which they will engage in such activities, and which activity will ultimately be reported for MIPS credit.

Recommendation: TMA recommends against increasing the group reporting threshold from at least one clinician to at least 50% of the group, and adding the requirement that at least 50% of a group's NPIs must perform the same activity for the same continuous 90 days.

Promoting Interoperability Performance Category

Overall, TMA asserts that CMS should allow more flexibility with PI category scoring so that physicians receive credit for measures met as opposed to the punitive all-or-nothing approach. CMS could accomplish this by making all PI measures a “yes/no” attestation rather than a numerator/denominator calculation.

Proposed Change to Query of Prescription Drug Monitoring Program (PDMP)

CMS is proposing to make the “Query of PDMP” measure optional and eligible for 5 bonus points for the 2020 performance year. Additionally, effective for the 2019 performance year, CMS is proposing to make the Query of PDMP measure a “yes/no” attestation rather than the numerator/denominator calculation currently required.

TMA agrees that CMS should make Query of the PDMP a “yes/no” attestation for performance years 2019 and 2020. Because EHR vendors are still working on PDMP integration, TMA further agrees that CMS should keep the measure optional and eligible for 5 bonus points. CMS should monitor state activities and encourage EHR vendors to integrate PDMP information into the physician's workflow to reduce administrative burden.

Recommendation: Make the Query of the PDMP a “yes/no” attestation and keep the measure optional with a 5-point bonus.

Verify Opioid Treatment Agreement

CMS is proposing to remove the optional and bonus measure, Verify Opioid Treatment Agreement. CMS explains that this particular measure was complex and burdensome to physicians, especially the 30-cumulative-day look-back period.

TMA agrees that CMS should discontinue this measure. CMS may consider making this measure an improvement activity that benefits physicians treating patients who need a pain management plan and opioid treatment agreement. CMS should not create additional opioid measures as part of promoting interoperability, but should rather place future opioid measures in the improvement activity category.

Recommendation: CMS should discontinue the Verify Opioid Treatment Agreement measure as part of the promoting interoperability category.

Modification of the Support Electronic Referral Loops by Sending Health Information Measures

CMS is proposing to modify the Send a Summary of Care measure effective for performance year 2019. The modification allows the redistribution of points to the Provide Patients Access measure when a physician claims an exclusion for the Send a Summary of Care measure.

TMA agrees that CMS should redistribute the points for Send a Summary of Care measure to the Provide Patients Access measure when claiming an exclusion. TMA further agrees that the points for both health information exchange measures should be redistributed to the Provide Patients Access measure when both exclusions are claimed. TMA agrees with CMS that this change should be effective for the 2019 performance year.

Additionally, CMS should recognize that while interoperability is improving, it is far from being an integrative part of the physician workflow. Physicians should have access to patient information from disparate systems with minimal cost and effort. TMA has heard from practices that devote significant resources to making interoperability work yet still struggle to get the relevant patient information in a manner that allows the EHR to consume the data and display it in an efficient manner to support clinical decision making at the point of care.

The primary method of electronic data exchange is still the Continuity of Care Document (CCD). Many practices and hospitals still do not have or use DIRECT addresses and are unable to receive an electronic CCD. As a result, practices that are able to send a CCD are unable to do so for groups that cannot receive them. As a result, physicians are unduly penalized for circumstances outside of their control. The CCD is also inadequate or insufficient information for many referrals – some specialties need additional data such as EKGs and other special studies. Practices still fax these additional results to the consultant, so this leads to a dual and disjointed process and excess effort. The receiving physician also receives multiple inbound methods of health information, making it more challenging to reconcile the information. Many EHRs still don't have an adequate capability to reconcile external data efficiently.

Recommendation: CMS should redistribute the points for Send a Summary of Care measure to the Provide Patients Access measure when physicians claim an exclusion. Additionally, effective for 2019 performance year, CMS should redistribute the points for both health information exchange measures to the Provide Patients Access measure when both exclusions are claimed. Finally, CMS should reduce the weight of the interoperability measures until interoperability is seamless, effortless, and meaningful.

Hospital-Based MIPS Eligible Clinicians in Groups

CMS is proposing a rule revision that specifies the Promoting Interoperability performance category be reweighted for hospital-based groups when 75% of the group's members qualify as non-patient facing.

Recommendation: CMS should reweight the PI category to zero for hospital groups when 75% of the group's members qualify as non-patient facing.

Request for Information (RFI) on the Provider to Patient Exchange Objective

CMS is seeking comment on an alternative measure under the Provider to Patient Exchange objective that would require clinicians to respond to patient requests via third party application programming interfaces (APIs).

TMA is concerned that there is unnecessary risk to patients when information is shared via APIs. Electronic end-user-agreements have legal language that is often incomprehensible to a layperson. While patients are entitled to their data, if they use third-party applications that are not HIPAA-compliant and that inappropriately share or use the data, the patient and physician could be dragged into a situation with a negative impact on the patient's medical future.

Recommendation: CMS should refrain from adding any new measures to the Promoting Interoperability category. If CMS moves forward with requiring physicians to send patient health information to third-party applications, then CMS should require that all third-party applications be HIPAA-compliant and use a standardized end-user agreement with language approved by CMS and the Office of Civil Rights that ensures the privacy of the patient's health information.

Request for Information on Patient Matching

CMS is requesting information on promoting interoperability and the need for patient matching without requiring a unique patient identifier (UPI).

TMA supports methods that ensure that patient data is not inappropriately matched or not matched when it should have been. Biometrics, algorithms, or other modalities such as "answer these personal questions" are helpful but not adequate. The best solution is a voluntary UPI approach.

A former chief health information officer of the Office of the National Coordinator recently wrote about the privacy-protecting benefits of a voluntary unique identifier. These (and others) include:

- It can be used by the patient when he or she is not present for a biometric comparison;
- It does not require a database of biometrics, which would be a huge risk if breached;
- If it were ever inappropriately disclosed/breached, creating a new unique identifier is much easier than changing the patient's personal information, such as mother's maiden name or what streets you lived on;
- If your current health ID is breached, all of your personal information is disclosed. With unique identifiers, no personal information needs to be transmitted or disclosed for health record sharing purposes, eliminating one of the major challenges in the current paradigm.

Recommendation: CMS should work with private-sector led initiatives that support a voluntary patient identifier.

Request for Information on Integration of Patient-Generated Health Data (PGHD) into EHRs using CEHRT

CMS is seeking information on whether physicians should capture PGHD and incorporate it into the EHR and if physicians should be incentivized to collect this information through the Promoting Interoperability category. CMS is suggesting that physicians may collect this information directly from patients or via wearable devices.

TMA is concerned that any measure requiring ingestion of patient-generated or wearable device data is problematic. It is difficult to manage data ingestion from multiple sources much less use it for clinical decision making. The variety of devices with different capabilities and measurements makes it difficult to normalize the data for analysis. Until EHR vendors provide significantly greater workflow-friendly support for this capability, CMS should not require it. This potential measure is overly burdensome to physicians.

Physicians clearly want to get data from patients and some already have limited mechanisms within the EHR to capture information provided by the patient. Until better standardized approaches are developed, it is dangerous to open EMRs in ways that could compromise security and safety by potentially introducing viruses, ransomware, and other malware.

It is also important for CMS not to inflate patient expectations. The number of wearables and other sources of PGHD is huge, and the ability of EMRs is limited. If patients have the expectation that the physician should import their data but the physician's EHR can't support this, it sows confusion and distrust in the physician-patient relationship.

Recommendation: CMS should not add these objectives or measures to the Promoting Interoperability category. If anything, the collection of PGHD could be an optional improvement activity.

Request for Information on Engaging in Activities that Promote the Safety of the EHR

CMS is requesting comment on physicians engaging in activities that promote the safe use of an EHR.

TMA applauds CMS for recognizing that technology creates new patient safety concerns. TMA has long advocated for the safe use of technology and is a collaborator with ECRI Institute's Partnership for Health IT Patient Safety.¹⁷ One way that CMS can take a leadership role is to fund a non-governmental aggregator of health information technology (HIT) patient safety events.

Physicians and other clinicians should be able to take a screen capture within the EHR or other HIT tools easily when there is erroneous functionality or other problems. The capture tool also

¹⁷ Partnership for Health It Patient Safety <https://www.ecri.org/solutions/hit-partnership>

would record key information about the computer system being used. The user could then use common tools to circle, highlight, or otherwise indicate the issue with a brief description and then submit the information to the designated safety-reporting aggregator organization. The entity could then determine if there are issues with the user's installation or if it is a system-wide problem requiring the vendor's immediate attention. It is important that this reporting be done nationally, as local reporting will not provide the volume of submission needed for accurate analysis.

Recommendation: CMS should fund a non-governmental aggregator of HIT-related patient safety events. This aggregator should be organized and maintained in a manner that prevents physicians from being exposed to increased litigation or liability based upon submissions to the aggregator. TMA further recommends that if CMS adds activities that promote patient safety in the EHR to the Promoting Interoperability category, these should remain optional and provide bonus points.

Additional MIPS Policies and QPP Components

Small Practice Bonus

In MIPS, small practices are defined as groups with 15 or fewer eligible clinicians. For the 2018 performance year, CMS established a small practice bonus policy and awarded small practices with five points to their overall MIPS final score to account for the unique challenges they face, as well as the performance gap for small practices in comparison to larger practices. However, for the 2019 performance year, CMS moved the small practice bonus from the overall MIPS final score to the quality category and awarded only six points to the quality category for small practices.

TMA is very disappointed that CMS did not revisit this policy for the 2020 performance year in light of evidence that demonstrates that small practices fared the worst in 2017. Physicians in solo and small group practices scored, on average, a total of only 43 points, whereas large practices and those who participated in MIPS APMs, scored, on average, 74 points and 87 points respectively. In addition, CMS' estimates in the 2020 proposed rule continue to show that physicians in solo and small group practices will disproportionately receive the payment penalty.

TMA believes adding only six points to the quality category is insufficient to support small practices and does little to promote a level playing field in MIPS.

Recommendation: To better support small practices and promote a level playing field, CMS should reverse its small practice bonus policy and apply five points to the overall MIPS final score instead of only six points to the quality category, beginning with the 2019 performance year. Upon transition to MVPs, CMS should revisit the policy and modify the small practice bonus accordingly.

Complex Patient Bonus

For the 2020 performance year, CMS proposes to continue to apply the complex patient bonus of up to five points to the MIPS final score. The complex patient bonus is intended to serve as a proxy and short-term strategy to address the impact patient complexity may have on MIPS scoring while the agency continues to work with ASPE and other stakeholders on methods to account for patient risk factors. CMS uses two indicators to measure a practice's patient complexity: 1) medical complexity is measured by the average Hierarchical Condition Category (HCC) risk score of beneficiaries treated; and 2) social risk is measured by the proportion of patients treated who are dually eligible to receive Medicare and either full or partial Medicaid benefits.

While we appreciate the complex patient bonus, TMA reiterates that it is not an adequate substitute for methodologies that could make measures fair for everyone.

Additionally, TMA urges CMS to improve its education about the methodology used to determine the complex patient bonus and the determination period used to calculate the average HCC risk scores so physicians and their practice staff may make improvements to their coding practices and actually benefit from this policy.

Recommendation: In the absence of adequate risk adjustment, CMS should continue to apply the complex patient bonus to the MIPS final score and urges the agency to identify methodologies that are fair for all physicians.

Virtual Groups

In MIPS, physicians can participate as individuals, groups, or 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 track. This option is completely voluntary and provides physicians in solo and small group practices with 10 or fewer clinicians the ability to join together for the purposes of MIPS participation regardless of specialty and location, and to have the flexibility to determine their own size.

According to TMA's Survey of Texas Physicians, small practices currently comprise 73% of physician practices in Texas (defined as eight physicians or fewer). Our 2016 survey data showed that 19% of physicians stated they were interested in joining a virtual group, and our 2018 survey data showed that 5% of physicians reported they were actively participating in a virtual group. When those not actively participating in a virtual group were asked if they were in the process of forming a virtual group or interested in joining or forming a virtual group for the 2019 QPP performance year, 1% reported they were in the process of forming one, 7% reported they were interested in joining or forming one, 14% reported they didn't know, and 79% reported they were not interested.

TMA is very disappointed that CMS has not placed much of an effort on emphasizing this option that is intended to level the playing field nor increased its outreach and education to physicians in

solo and small group practices. To date, minimal information about virtual groups has come through the agency's communication channels and QPP website.

Recommendation: To help physicians in solo and small practices succeed in MIPS, TMA urges CMS to do more to help physicians explore this option and expand its technical assistance for virtual groups beyond the 2019 performance year. We further urge the agency to publish both national and state data on virtual group participation in 2018 and 2019 so stakeholders can evaluate its uptake and overall performance data to inform comments moving forward.

Reweighting Performance Categories Due to Data That Are Inaccurate, Unusable, or Otherwise Compromised by Third-Party Intermediaries (Vendors) or Agents

CMS refers to MIPS-related vendors as third-party intermediaries. These are entities the agency has approved to submit data on behalf of physicians: QCDR vendors, qualified registry vendors, health information technology (IT)/EHR vendors, or CMS-approved survey vendors. While CMS "approves" these vendor types for the QPP, it does not evaluate any specific entity's capabilities, quality, features, or products. CMS directs physicians to conduct their own due diligence when it comes to the entities the agency approves as being "qualified" to submit data for the QPP.

The agency implemented a new policy for 2019 that allows physicians to submit MIPS data through as many data collection types as necessary, which likely increased utilization of all vendors. While the use of multiple data collection types can help maximize scoring, administrative and cost burdens associated with vendors and quality reporting remain. Physicians making a good faith effort to meet all data requirements continue to report to TMA that they suffered data errors committed by vendors and oftentimes were not reimbursed for the fees they paid for reporting through the vendor. Worse, CMS did not change their scores nor removed payment penalties.

Over the years, TMA has strongly urged CMS not to penalize physicians when vendors failed at any step of the data collection and submission process, especially when the issue was out of physician control. CMS now proposes to create a new policy for this situation. Specifically, CMS proposes to reweight performance categories for physicians whom the agency determines has data for a performance category that are inaccurate, unusable, or otherwise compromised due to circumstances outside of the control of the physician or its agents, if it learns the relevant information prior to the beginning of the associated MIPS payment year.

TMA applauds CMS and fully supports finalizing this physician-friendly policy. We are also pleased that the agency proposes to apply this policy beginning with the 2018 MIPS performance period and 2020 MIPS payment year. However, we believe the time frame for notification of compromised data should stretch into the payment year for instances in which physicians may not know about data errors until they begin to receive payment adjustments.

Additionally, TMA notes that CMS states the term "agent" in this proposal is intended to include any individual or entity, including a third party intermediary as described in §414.1400 (which

are the vendors noted above), acting on behalf of or under the instruction of the MIPS-eligible clinician. We seek clarification and definitions for the term “any individual or entity.” Over the years, many physicians have informed TMA that data errors were committed by their own practice staff who were simply trying to navigate the program to collect and submit data on their behalf in good faith but were unable to successfully submit data due to confusing data requirements and the program’s complexity. We have also heard from physicians that billing vendors, practice vendors, consultants, or chart abstractors were the root cause of data errors or incomplete reporting. For these reasons, TMA urges CMS to ensure that the terms “any individual or entity” include practice staff, billing vendors, practice vendors, consultants, chart abstractors, and the like.

Recommendation: TMA strongly supports and urges CMS to finalize its proposal “to reweight the performance categories for a MIPS eligible clinician who the agency determines has data for a performance category that are inaccurate, unusable, or otherwise compromised due to circumstances outside of the control of the clinician or its agents if CMS learns the relevant information prior to the beginning of the associated MIPS payment year. TMA urges CMS to extend the time frame for notification of compromised data into the MIPS payment year. TMA further urges CMS to ensure that the terms “any individual or entity” include practice staff, billing vendors, practice vendors, consultants, chart abstractors, and the like.

Performance Feedback

We continue to believe that timely performance feedback is critical to the success of MIPS and to those who wish to transition to APMs. If physicians cannot access and confidently evaluate their data, how can they improve their performance? MACRA requires that CMS at a minimum provide physicians with timely (such as quarterly) confidential feedback on their performance under the quality and cost performance categories. CMS also lists among its QPP strategic objectives that it will “improve data and information sharing on program performance to provide accurate, timely, and actionable feedback to clinicians and other stakeholders.” However, the current timeframe for official performance feedback and MIPS final scores is seven months after the close of the performance year.

TMA appreciates the enhanced feedback that CMS would like to see provided by QCDRs and registries in the future, such as more than 4 times a year. However, these vendors do not provide cost data, and not all physicians report data through these methods. Without timely and actionable data to drive improvement across all practices and data collection types, Congress may not see the improvements in individual patient and population health outcomes it intended through MACRA legislation.

Furthermore, we continue to hear from physicians 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

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

More importantly, we seek data on how many physicians understood their performance feedback, MIPS final score, and payment adjustment determinations. CMS should consider collecting data on this last question at the time physicians access their performance feedback directly on the QPP portal

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 in a timely manner within the performance period. We further urge CMS to improve its education surrounding performance feedback as well as report data that show how many physicians access their performance feedback annually.

Targeted Review

Rather than provide 90 days, CMS proposes to change the targeted review request period next year by narrowing the window to 60 days that would begin on the day the agency makes performance feedback, MIPS final scores and payment adjustments available to physicians.

During the first targeted review period which was held last year, CMS reports it received many targeted review requests that were duplicative and seeks opportunities to limit burden and improve the efficiency of its processes. Therefore, CMS proposes that targeted reviews may be denied if: 1) the request is duplicative of another request for targeted review; 2) the request is not submitted during the targeted review request submission period; or 3) the request is outside of the scope of targeted review.

TMA appreciates that physicians have the opportunity to appeal data or calculation errors through the targeted review process so they can base their quality and cost improvement efforts on accurate data. We remind CMS that during the first targeted review period which was held last year for the 2017 performance year, the agency identified errors and had to re-calculate MIPS final scores and payment adjustments and issue revised performance feedback to physicians.¹⁸ TMA believes it was likely due to these errors that caused many of the duplicate requests.

To reduce physician burden and because of their busy patient care schedules, TMA opposes narrowing the targeted review window from 90 to 60 days. TMA further opposes denying a targeted review request if it is duplicative of another request for targeted review. We believe this policy would be punitive to physicians who in good faith are trying to navigate the process and fix an apparent issue in their performance feedback, MIPS final scores, and/or payment adjustment determination.

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

¹⁸ Medicare Gets It Wrong, Re-Calculates MIPS Scores and Changes 2019 MIPS Payment Adjustments. (September 18, 2018). *Texas Medicine Today* <https://www.texmed.org/TexasMedicineDetail.aspx?id=48590>

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. Furthermore, to ensure program transparency, CMS should provide detailed written feedback based on the results of targeted reviews.

Lastly, we request that CMS publish a summary of trends and issues identified during the targeted review process so TMA and others can evaluate the information and develop resources that would help inform physicians about how to avoid the pitfalls to program participation.

Recommendation: To reduce burden and provide physicians with a sufficient opportunity to appeal inaccurate data or calculation of their MIPS payment adjustments, CMS should expand the targeted review period to 90 days and beyond a one-level process, and not deny duplicate requests but rather combine and address them in a non-punitive manner. The agency should make further improvement surrounding the targeted review period as noted above.

Data Validation and Auditing

Current policy requires that physicians who submit data for MIPS must certify to the best of their knowledge that the data submitted is true, accurate, and complete.

CMS reports that MIPS data that are inaccurate, incomplete, unusable, or otherwise compromised can result in improper payment. The agency reports that using data selection criteria to misrepresent a physician's performance for an applicable performance period, commonly referred to as cherry picking, results in data submissions that are not true, accurate, or complete, and violates existing regulatory requirements.

If CMS suspects cherry picking of data, the agency will subject physicians to an audit and, in the case of improper payment, will reopen and revise the MIPS payment adjustment.

Recommendation: TMA recommends that CMS add an additional component to the policy that takes into consideration submissions by physicians who simply intend to report minimal data to achieve the default three-point floor for each measure. TMA further recommends that CMS add a feature within the portal that would allow physicians to inform the agency that their submission is intended for minimal reporting.

Public Reporting on Physician Compare

For future years of the program, CMS is considering to propose developing and reporting on Physician Compare a "value indicator" representing each physician's performance on cost, quality, and patients' experience of care. The agency reports that user testing for the Physician Compare website has repeatedly shown that Medicare patients and caregivers greatly desire narrative reviews, quotes, and testimonials by their peers, and a single overall "value indicator" reflective for each physician, similar to their experiences with other consumer-oriented websites.

While TMA acknowledges that MACRA directs CMS to publish MIPS scores and aggregate information on the Physician Compare website, we urge the agency to reconsider the type of data it reports publicly in light of the fact that the entire program remains highly flawed. When it comes to Physician Compare, TMA would like to ensure that the measures and methodology used for the website are fair, transparent, and valid, that physicians are involved in the development of the standards to evaluate physician performance,¹⁹ and that decisions to display data are not driven just by the wishes of CMS and Medicare beneficiaries and their caregivers.

As previously stated, the agency has not yet implemented statutorily-required adequate risk adjustment to cost and quality measures resulting in flawed performance measurement methodologies, inadequate and unfair scoring policies, lower performance scores for many physicians, and tarnished physician reputations via data already publicly reported on the Physician Compare website. Adding subjective patient ratings and narrative reviews, which oftentimes have nothing to do with the quality of care patients receive, would further exacerbate the program's problems. Additionally, we believe adding a value indicator representing overall performance before full implementation occurs in 2022, and before the program's underlying issues are resolved, would be very misleading to the public and harmful to physicians.

Furthermore, TMA appreciates the agency's proposal to amend regulatory text, as required by MACRA, stating that the "information made available on the Physician Compare website indicates that publicized information may not be representative of an eligible clinician's entire patient population, the variety of services furnished by the eligible clinician, or the health conditions of individuals treated." However, we believe "seeing is believing," and the public may ignore any such statement posted on the website and consider physicians' MIPS scores and other data as a true representation of their quality of care.

At most, TMA recommends that public reporting on Physician Compare simply display whether physicians participated in the program until all program issues have been resolved.

Recommendation: To prevent tarnished physician reputations, TMA recommends that public reporting of specific MIPS scores on Physician Compare be delayed until there is adequate risk adjustment and appropriate attribution, and overall more predictability, continuity, consistency, and decreased complexity in the program. To decrease physician burden, the Physician Compare preview period should span 90 days along with the release of MIPS performance feedback and the targeted review period. For physicians who file a targeted review due to questions pertaining to their MIPS scores or data errors, CMS should refrain from publishing their scores until such issues are resolved.

MIPS Value Pathways (MVPs) Request For Information (RFI)

Overview

CMS proposes to transform MIPS through the development of new MIPS Value Pathways (MVPs), which would move physicians away from siloed activities and measures and include an

¹⁹ TMA Policy 195.032 Federal Physician Compare Website <https://www.texmed.org/Template.aspx?id=43133>

aligned set of measures that the agency reports would be more meaningful and clinically relevant to physicians and patients. The agency reports that MVPs would allow for more streamlined reporting, reduce reporting burden, and facilitate movement to APMs.

TMA appreciates the agency's efforts to transform MIPS into an improved system that reduces physician burden and thanks the agency for the opportunity to provide input on the MVP proposal.

While we did not find the initial description of the MVP framework to differ much from the existing MIPS structure, we welcome the concept and stand ready to assist the agency with solutions that would result in a program that Texas physicians can champion to further improve the health of their Medicare beneficiaries and all Texans.

MVP Guiding Principles

CMS seeks feedback on the four guiding principles the agency would use to define MVPs:

1. MVPs should consist of limited sets of measures and activities that are meaningful to clinicians, which will reduce or eliminate clinician burden related to selection of measures and activities, simplify scoring, and lead to sufficient comparative data.
2. MVPs should include measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers in evaluating clinician performance and making choices about their care,
3. MVPs should include measures that encourage performance improvements in high priority areas, and
4. MVPs should reduce barriers to APM participation by including measures that are part of APMs where feasible, and by linking cost and quality measurement.

We remind CMS that the clinician burden related to the selection of measures is due to an insufficient number of measures by specialty, measures type, and physicians' preferred data collection method to meet the complex data requirements that the agency has created. Because of this, CMS' current scoring policies and bonus point system offer unfair advantages for some physicians because the program does not provide all physicians with an equal opportunity to achieve the most points, including bonus points. This results in an inequitable assessment of performance and a perception of some physicians being high-quality performers than others simply because they had more measures and bonus point opportunities available to them to achieve to those higher scores.

TMA asserts that offering a limited set of measures and activities through MVPs would not engage physicians because physicians seek measures and activities that are clinically relevant and meaningful to them, not necessarily to what the agency deems should be bundled together or designated as high priority areas. Instead, TMA would support requiring a minimum number of measures (fewer than 6) and activities for which to report for MVPs according to physician choice. We also would support efforts that would make scoring policies fair for all physicians. Additionally, we would support measures that are part of APMs only if they have gone through the standard vetting and approval process established by the medical profession.

We acknowledge that comparative data would be good information to know for some. However, we would oppose such a system if such data would come at the expense of physicians having to pay to collect and submit data on measures they do not find meaningful to their practices, specialties, and patients. MACRA does not require that physicians report data on a uniform set or a particular number of measures and activities; MACRA does not state that data must be sufficient for comparison; the law requires only that MIPS performance scores be published on the Physician Compare website.

Given the new opportunity to transform MIPS, we offer these guiding principles, which we believe would result in significant improvements to the program, increase physician engagement in MVPs, and accelerate the movement to value-based care and APMs for physicians who wish to do so:^{20,21,22}

1. MVPs should be patient-centered and foster the patient-physician relationship;
2. MVPs should be strictly voluntary and pilot tested to establish proven methods aimed at promoting quality patient care that is safe and effective, and not just to achieve monetary savings;
3. MVPs should have no budget neutrality requirement that pits physicians against each other;
4. MVPs should be non-punitive and provide fair and equitable incentives from supplemental funds that do not come from payment penalties assessed on physicians and other clinicians;
5. MVPs should be available to, and include fair scoring policies for, all physicians and specialties wishing to participate and must not favor one specialty over another, nor favor physician practices by size, location, setting, or HIT capabilities;
6. MVPs should offer a sufficient number of measures to choose from that are fair, evidence-based, clinically relevant, and meaningful quality and cost performance measures under physician control and that have a direct benefit to their patients, including appropriate attribution and adequate risk adjustment, and that do not penalize physicians with patients in disadvantaged or high-risk populations;
7. MVPs should be customizable and include measures and activities that encourage and support physicians' own quality and performance improvement goals for their respective practices, patient populations, specialties, and settings;
8. MVPs should offer physicians the ability to determine how best to use their EHR with simple attestation for promoting interoperability and improvement activities of their choice;
9. MVPs should provide timely, accurate, meaningful, and actionable performance feedback in an easy to understand format, and offer fair appeals and auditing processes in a non-punitive manner;

²⁰ TMA Policy 195.038 Improving the QPP and Preserving Patient Access <https://www.texmed.org/Template.aspx?id=50941>

²¹ TMA Policy 265.017 Pay-for-Performance Principles and Guidelines <https://www.texmed.org/Template.aspx?id=43393>

²² TMA Policy 195.033 Medicare Payment Incentives and Penalties <https://www.texmed.org/Template.aspx?id=43134>

10. MVPs should include adequate payment policies that enable physicians to address social determinants of health and compensate them for doing so;
11. MVPs should include data on the Physician Compare website only if such data are based on measures and methodologies that are fair, evidenced-based, transparent, and valid; do not include subjective information; and practicing physicians are involved in the development of the standards to evaluate physician performance; and
12. MVPs should provide reimbursement from CMS for any added administrative costs incurred as a result of collecting and reporting data.

TMA strongly opposes MVPs that do not meet these guiding principles.

Recommendation: To support a fair and ethical program, and promote physician engagement, CMS should follow TMA’s guiding principles to define and develop MVPs.

Development of MVPs

CMS seeks feedback on the MVP examples in Table 34 of the proposed rule that might help the agency in its development of additional MVPs. The examples demonstrate how MVPs could be constructed and show the types of measures and activities that might be assigned to each MVP. CMS asks if MVPs should include only required measures and activities, or a small list of quality measures and activities from which clinicians could choose what to report.

Unfortunately, TMA’s analysis of the agency’s MVP proposals in Table 34 show no significant change from the current MIPS reporting structure. Physicians today can create their own MVP-like set of bundled measures and activities that would mirror the examples provided. The only apparent difference is three fewer quality measures they would have to collect and report. Nonetheless, physicians still would have to pay to collect and report data on measures, plus be assessed on a new population health measure that has yet to be proven scientifically valid and appropriate within the context of existing methodologies used to assess physician performance, which currently have been proven to be highly flawed.

As a compromise, CMS could create MVPs that are meaningful to the agency with input from the applicable specialties, but also offer physicians the option to customize their own MVP. Without this option, TMA would oppose the agency’s MVPs entirely.

Recommendation: To promote physician engagement, MVPs should not be prescriptive, but rather support physician choice by offering physicians the ability to select their own measures and activities that are clinically relevant and meaningful to their practices, specialties, and patients.

Selection of Measures and Activities for MVPs

CMS seeks feedback on what criteria it should use for determining which measures and activities to include in an MVP, such as prioritizing outcome, high priority, and patient-reported measures; limiting the number of quality measures to four; including only cost measures that align with quality measures, etc. The agency asks how performance categories and associated measures and

activities should be linked and whether clinicians and groups should be required to use a certain collection type in order to have a comparable data set in the MVPs. CMS also inquires about potential administrative burden for changing to a new, specific collection type for a measure.

We believe the MVP framework described in the proposed rule falls short of accomplishing the stated goals, and CMS should prove the concept before implementing MVPs.

While CMS reports MVPs would be more meaningful and would reduce burden, we believe the administrative and cost burdens associated with program participation have the potential to increase. For example, TMA anticipates changes to existing reporting methods, such as requiring physicians to submit data only through electronic means or registry vendors. Such a scenario likely would require EHR system updates involving costs that vendors may pass on to physician practices. In addition, because MVPs would include predefined sets of measures and activities, physicians would lose the freedom to choose the measures and improvement activities that are most meaningful to their practices, specialties and patients.

Even if CMS reduces the required number of measures physicians must report, the agency still should provide multiple measure options rather than restrict them by specialty. The agency should offer more options for the quality category, including how the measures are reported. CMS should never prioritize any individual measure, which is an issue that exists in MIPS today that contributes to physician burden related to the selection of measures, and affects scoring, bonus points, performance, and payment adjustments.

The agency also should not restrict the available options of improvement activities. Physician practices vary greatly by geographic region, size, specialty, and sophistication of collective staff. Similarly, the areas of improvement and chosen activities will vary. CMS needs to provide more detail before trying to align improvement activities with measures or by specialty or condition. TMA believes physicians should have multiple options for improvement activities within each specialty and condition. More importantly, documentation and quality reporting should be simplified to minimize administrative burden, and physicians should not be unduly burdened with data collection and reporting.

Depending on the collection method for patient-reported outcomes, physicians may have to incur additional costs, further increasing their burdens for regular MIPS participants. Moreover, we believe it is premature to require patient-reported outcomes when measures and instruments to collect such data are currently limited and data may be subjective. Furthermore, cost measures for MVPs should include only measures under physician control, including appropriate attribution and adequate risk adjustment, and that do not penalize physicians with patients in disadvantaged or high-risk populations.

TMA appreciates that physicians would receive additional performance feedback in the future state of MVPs, but we point out that per MACRA the agency should have been offering such data since the program first implemented in 2017. If the agency plans to leverage the vendor community to provide additional performance feedback, TMA is concerned that vendors would pass those costs on to physician practices when CMS should offer the data at no costs to physician practices.

We remind CMS that it plays a significant role in contributing to physician burden and burnout by continuously changing program requirements. System changes within any organization, large or small, require software changes, software testing, rewritten policies and procedures, physician and staff training, report writing, patient education, and many other details that are time consuming and expensive to implement. Prior to making any programmatic changes, CMS should test the concepts and provide evidence-based data that proves these new regulations positively affect outcomes. The EHR vendor community is continuously tasked with making changes to satisfy CMS-program compliance for its users. This takes time away from usability, care improvement, and patient-safety software improvements that would stand to benefit patients and physicians far more than a repackaging of MIPS. For these reasons, MVPs should offer physicians the ability to determine how best to use their EHR with simple attestation for promoting interoperability.

Furthermore, we believe physician preference would vary across all practices and potential configurations of measures and activities, MVP focus areas, and depend on their existing practice infrastructure for the collection and submission of data. Given the number of measures CMS proposes to remove in 2020, and the limited number of measures many physicians report they have available to them, TMA recommends that the agency consider starting by requiring fewer than four measures to report, such as one to two, and build from there. The agency also should consider decreasing the number of quality measures physicians must report for the 2020 performance year to evaluate which measures are most meaningful to physicians, and which configurations are most prevalent among all measures and improvement activities. TMA believes this approach would provide evidence and data that would help to inform the agency's selection of pre-defined sets for the MVPs.

Lastly, we ask that CMS keep in mind that physicians must comply with multiple public and private payer policies. Each payer has value-based programs with varied standards and reporting requirements. TMA urges CMS to build on the work of national initiatives, such as the Core Quality Measures Collaborative, to align more of its measures across payers.²³ The U.S. health care system would benefit by agreement of program standards such as other professions and industries have done. In addition to this RFI, we further urge CMS to work with physician associations, specialty societies, and other payers to create common pathways for value-based care.

Recommendation: To relieve physician burden, the selection of all measures and activities should be left to the discretion of physicians and MVPs should not require a certain collection type. The agency should decrease the required number of quality measures physicians must report for the 2020 performance year to evaluate which measures and improvement activities are most meaningful to physicians and the configurations that are most prevalent.

MVP Assignment

²³ AHIP, CMS, and NQF Partner to Promote Measure Alignment and Burden Reduction. <https://www.qualityforum.org/cqmc/>

CMS seeks feedback on how it should identify which MVPs are most appropriate for physicians and whether it should be based on the specialty as identified in PECOS or the specialty reported on claims. If the agency assigns an MVP, it asks how it would be able to verify the applicability of the assigned MVP. CMS also asks whether it should allow clinicians to select their MVP from among more than one applicable MVP offered. The agency further asks what tools would be helpful for clinicians to understand what MVP might be applicable.

TMA recommends that CMS refrain from assigning MVPs as we do not believe physicians would be receptive to mandatory assignments. Instead, and as a starting point, TMA recommends that CMS inform physicians which MVPs are most likely applicable to them based on the information in PECOS and specialty reported on claims. TMA reiterates that the agency should not be prescriptive as to which MVP a physician must engage in and which measures they must pay to collect and report and thus, be displayed on Physician Compare. Since physicians know their patient panels best, TMA feels strongly that MVP selection should be left to the discretion of physicians.

Recommendation: Rather than assign MVPs to physicians, CMS should simply inform physicians which MVPs are likely most applicable to them. MVP selection should be left to the discretion of physicians. To inform physicians about MVP options, the agency should offer a lookup tool on its QPP website as well as inform physicians within the QPP portal as to which MVP is most applicable to them based on enrollment and other relevant Medicare data.

Transition to MVPs

CMS seeks feedback on how to transition to MVPs beginning with the 2021 MIPS performance period and 2023 MIPS payment year. Specifically, the agency asks what practice-level operational considerations it needs to account for in the timeline for implementing MVPs.

Because the MIPS program is dependent on technology and third-party intermediaries, TMA believes that physicians would be at the mercy of their practice vendors in the transition to MVPs. Like MIPS, physician readiness would depend on whether their vendors have made the necessary updates to support MVP participation. For this reason, we strongly recommend that the burden of program participation be shifted from physicians and onto the vendor community. Physicians should not be required to collect and submit data if their vendors do not already have the capability to support program participation at no additional cost. Data collection and submission process should be standardized across all vendors.

Conversely, CMS should offer alternative program participation options for physicians who do not have EHR systems or do not wish to use registries. There are many physicians who do not have EHR systems either by choice, other reasons, or because they plan to retire from practice within a few years and would not receive a return on investment for transitioning their practice from paper charts to an EHR system. In addition, many physicians still rely on and successfully report quality data via the claims-based reporting option.

In-depth physician education would be required to prepare physician practices for clinical performance in MVPs. TMA urges CMS not to use the same approach as currently exists in MIPS where the agency sends daily and weekly emails, hosts webinars during the day when physicians are busy seeing their patients, and publishes numerous fact sheets, resources, and guides on the QPP website in piecemeal fashion throughout the performance year. TMA believes the agency's practice of issuing information randomly throughout the year significantly contributes to physician burnout.

Lastly, we believe a slow ramp up is the best approach so the agency can continue to refine its policies and avoid subjecting physicians to another failed program that does little to improve quality and population health outcomes or reduce costs, but further adds to physician burden.

Recommendation: TMA recommends that CMS first pilot test MVPs and use a phased approach to program implementation over the course of several years. When transitioning from MIPS to MVPs, the burden of program participation should be shifted away from physicians and onto the vendor community. CMS should also offer alternative program participation options for physicians who wish to participate other than through EHR systems and registries. To prepare practices for MVPs, there should be one national initiative with comprehensive education that is fully accredited with formal continuing medical education credits and offered to both physicians and practice staff at no cost.

Small and Rural Practices Participation in MVPs

CMS seeks feedback on how MVPs should be structured to provide flexibility for small and rural practices and to reduce participation burden.

We reiterate that MVPs should be strictly voluntary. For those who choose to participate, TMA believes small and rural practices should be offered as much flexibilities as possible and should engage in MVPs according to their capabilities. The biggest lesson learned from MIPS is that a one-size-fits-all approach does not work. The association reiterates the importance of adopting our guiding principles to define the MVPs. We feel strongly that offering voluntary participation and financial incentives without fear of failure or penalty is the best approach CMS could take to engage physicians, particularly those in small and rural practices.

An innovative solution the agency could implement is to allow physicians in small and rural practices an opportunity to engage in MVPs through incremental steps or building blocks. For example, for the purpose of an incentive payment, small and rural practices who wish to participate in MVPs could be offered a non-punitive approach where they would focus on only one category of their choice per performance year. This would give them the option to start with only one category at a pace that is realistic to manage while they receive technical assistance and/or transform their practices.

After four years, practices could then focus on two or more categories until they are able to handle all four and fully participate in MVPs – with reduced and/or modified data requirements and special scoring policies, if needed. However, CMS would have to reevaluate the issue of insufficient case mix to report measures that can be reliably scored for certain measures and

ensure adequate risk adjustment and appropriate attribution methodologies are used. If these problems cannot be resolved, physicians in small and rural practices should always be exempt, unless they choose to opt in or voluntarily report.

Recommendation: Small and rural practices who wish to voluntarily participate in MVPs should be offered a non-punitive and incremental approach with as much flexibilities as possible.

Multispecialty Practices Participation in MVPs

CMS seeks feedback on multispecialty practices participation in MVPs.

Theoretically, it seems it would be better to require use of specialty-specific measures, but if there are not enough options then the program is too restrictive. In today's practice environment, it is more practical and efficient to use the same set of measures with all physicians within a multi-specialty group. Broader data collection requirements could impose significant burden for the practice and for EHR developers.

Practices sometimes choose measures based on what they can discretely capture within their EHR rather than reportable by other collection methods. One example is the osteoarthritis measure. That requires capture of functional and pain assessment, which cannot be measured discretely without significant and costly change requirements within the EHR.

For multispecialty groups, having multiple MVPs and measures for each pathway to manage may create undue administrative and reporting burden, but that decision should be left to each group. Also, the QPP already offers specialty-specific measure sets that are optional and are used if they make sense for the overall practice.

Recommendation: CMS should not restrict measure options for multispecialty practices participating in MVPs.

Incorporating QCDR Measures Into MVPs

CMS seeks feedback on whether it should integrate QCDR measures into MVPs along with MIPS measures, or if they should limit them to specific MVPs consisting of QCDR measures only. The agency also asks how to continue to encourage clinicians to use QCDRs under MVPs.

TMA acknowledges that participation in high-quality QCDRs can provide value to physicians who wish to use them. We reiterate that MACRA does not require participation in QCDRs, but rather directs CMS to encourage their utilization. Given that we encourage CMS to offer a customizable MVP option, we recommend that the agency continue to allow physicians to use QCDR measures for the quality category.

Recommendation: CMS should allow physicians to participate in MVPs and use QCDR measures for the quality category. To encourage the use of QCDRs, CMS should continue to offer improvement activities credit to physicians who participate in QCDRs.

MVP Population Health Quality Measure Set

CMS seeks feedback on specific administrative claims-based quality measures it should consider for MVPs. The agency also questions whether administrative claims-based quality measures should replace some of the reporting requirements in the quality performance category.

TMA's 2018 Survey of Texas Physicians showed that 59% of physicians believed that reporting requirements in the QPP should be eliminated and that practices should be evaluated based on information available from filed claims.

However, we caution CMS against adding new measures that do not meet our criteria. Otherwise, the same issues in MIPS will continue in MVPs resulting in another flawed program.

Recommendation: CMS should use only quality and cost performance measures that are in physician control and include appropriate attribution and adequate risk adjustment methodologies that do not penalize physicians with patients in disadvantaged or high-risk patient populations.

Request for Feedback on Clinician Data Feedback

CMS reports it would like to provide meaningful clinician feedback on administrative claims-based quality and cost measures and seeks feedback on particular data from quality and cost measures that would be helpful.

TMA has heard from physicians that report that current MIPS performance feedback is challenging to interpret. The transition to MVPs presents an opportunity to start anew and quite frankly, get it right the first time. We believe obtaining responses directly from all physicians would be best to inform its clinician data feedback. For example, via the QPP portal, CMS should conduct a physician survey at the same time it offers MIPS performance feedback to physicians. The agency could inquire about the level of granularity, outlier analysis, or other types of actionable feedback physicians would find most helpful. This method and approach would inform the agency with exactly the data elements and information physicians seek.

TMA believes the absence of timely performance feedback undermines the intent of MACRA and CMS should improve its efforts to simplify and provide timely feedback during the performance period at no cost to physicians.

Recommendation: Via the QPP portal, CMS should conduct a physician survey at the same time it offers MIPS performance feedback to physicians to inquire about the level of granularity, outlier analysis, or other types of actionable feedback they would find most helpful.

Patient Reported Measures and Publicly Reporting MVP Performance

CMS seeks feedback on what patient experience/satisfaction measurement tools or approaches to capturing information would be appropriate for inclusion in MVPs. The agency also seeks comments on what considerations should be taken into account if it publicly reports a value indicator, as well as corresponding measures and activities included in the MVPs.

The agency has not yet implemented statutorily required adequate risk adjustment to cost and quality measures resulting in flawed performance measurement methodologies, inadequate and unfair scoring policies, lower performance scores for many physicians, and tarnished physician reputations via data already publicly reported on Medicare's Physician Compare website. TMA believes adding a value indicator to physician profiles on Physician Compare while so many program issues remain would be unwelcomed in MVPs and unfair and harmful to physicians.

It is difficult to weigh on these subjects without a full description of the measurement tools and methodologies CMS would use to calculate physician scores as well as the administrative and cost burdens associated with collecting and reporting patient experience and patient reported outcomes. Already TMA opposes the CAHPS for MIPS and maintains that the survey remain optional. It has very high vendor fees and comprises subjective information the association believes should not be tied to physician payment. Patient experience and satisfaction surveys should be left to the discretion of each practice.

While we understand CMS seeks comparative performance data that the agency reports would be valuable to patients and their caregivers, TMA believes that emphasizing this aspect of the new MVP framework will only deter physicians from engaging in the program.

To increase physician confidence in CMS' ability to implement a successful value-based payment system that is fair for all physicians, TMA suggests that the agency scale back its desire to elevate the Physician Compare website to a level that promotes program data as an all-encompassing evaluator of a physician's worth. Many physicians view the existing measures as failing to capture accurately the quality of their practice and specialty as a whole. CMS should first and foremost work on simplifying the program to relieve physician burden and focus on improving its quality measures portfolio and performance measurement methodologies before planning to provide value indicators and comparative performance data to the public. Without those improvements, TMA strongly opposes reporting additional data on the Physician Compare website.

Recommendation: TMA recommends that the agency first resolve issues with its lack of sufficient measures and flawed performance measurement methodologies before considering publishing additional data on the Physician Compare website.

ALTERNATIVE PAYMENT MODELS (APMs)

Advanced APMs Bonus

As of September 23, the 2019 5% lump-sum bonus payments had not been paid to the 99,076 clinicians who achieved qualifying APM participant status in Advanced APMs in 2017. TMA believes this delay in payment is not fair to physicians to wait almost a full three years from the beginning of the 2017 performance year to be financially rewarded. We urge CMS to be transparent about the delay in payment and learn from this problem so that it does not recur.

These bonuses are intended to help cover practice costs as physicians continue to make investments in practice transformation efforts. TMA believes that physicians and other clinicians in Advanced APMs who have made a good faith effort to transition to risk-based models deserve to be rewarded in a timely manner as intended by MACRA and Congress.

Furthermore, while outside the scope of rulemaking, TMA advocates for Congress to extend the 5% bonus beyond 2024 so that as new models are implemented, physicians have added support to help cover start-up costs to help facilitate their ongoing participation in Advanced APMs.

Recommendation: TMA urges CMS to issue the 2019 5% Advanced APMs to physicians and other clinicians who achieved qualifying APM participant status in 2017 immediately. We also urge CMS to be transparent about the delay in payment and take appropriate steps to prevent it from recurring.

Advanced APMs

For the 2020 performance year, CMS estimates that 175,000 to 225,000 clinicians nationally would qualify for the Advanced APM incentive payment in 2022. These numbers show that participation will double in 2020 compared to the 99,076 clinicians who participated in the Advanced APM track in the 2017 performance year.

While we acknowledge growth in Advanced APM participation, we urge CMS to continue its efforts to encourage the development of a broad range of models that would provide opportunities for more physicians who do not currently have an Advanced APM available to them, including models with a slow ramp-up to financial risk. TMA reiterates that APMs and Advanced APMs must be designed to attract physicians to participate voluntarily in models proven to help them treat their Medicare patient population safely and more effectively.

Furthermore, TMA strongly urges CMS to publish state data to inform stakeholders about the number of Texas physicians and other clinicians who have participated in Advanced APMs since 2017. We found no data in the 2017 QPP experience report that would help to inform our ongoing comments. The association also urges CMS to increase its transparency so we can evaluate the data to better identify physician trends as they move to value-based care and innovative payment models.

Recommendation: CMS should prioritize physician-led models of care and Advanced APMs that offer participation opportunities for physicians in all specialties and practice sizes. TMA urges CMS to increase its transparency by publishing state data pertaining to Advanced APM participation.

Nominal Risk Amount

For the Medicare Advanced APMs and Other Payer Advanced APMs, CMS proposes to amend financial risk standards to require that the “expected expenditures” for which an APM Entity is responsible under an APM be no higher than the “expenditures that an APM Entity would be expected to incur in the absence of the APM,” and to exclude the “excess expenditures” when considering whether the APM meets the financial risk standards for Advanced APM status.

TMA believes the current nominal risk amount hinders physicians in smaller practices from transitioning to the Advanced APM track. In light of the MVP proposals and the focus on facilitating movement to Advanced APMs, TMA urges CMS to ensure additional APM models do not force practices to accept more risk than they can financially manage. Advanced 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.

Recommendation: TMA opposes the proposed changes to the financial risk standards for Medicare Advanced APMs and Other Payer Advanced APMs. CMS should have a lower nominal risk amount for physicians in small and rural practices.

Partial PQ Status

For the 2020 performance year, CMS proposes that partial qualifying participation (QP) status would apply only to the TIN/NPI combination(s) through which an individual eligible clinician attains partial QP status. This means that an eligible clinician who is a partial QP for only one TIN/ NPI combination may still participate in MIPS for other TIN/NPI combinations.

TMA believes that because of the complexity of the Advanced APM track and default pathway to MIPS, many physicians are not fully aware of their options in the QPP. While this policy is intended to provide physicians who have achieved partial QP status in the Advanced APM track an opportunity to submit data to MIPS for other TIN/NPI combinations, we seek clarification as to whether they would receive the automatic 9% payment penalty for not submitting data for the other TIN/NPI combinations.

With the increased participation rates in Advanced APMs and higher Medicare amount and patient count thresholds, we anticipate that many physicians would fall under this scenario next year and receive a payment penalty for not fully understanding their options. For this reason, we oppose this proposal and instead urge CMS to allow partial QPs the ability to opt in rather than require submission of data for their other TIN/NPI combination(s) not affiliated with their APM entity.

Recommendation: CMS should allow partial QPs to opt in to MIPS rather than require submission of the data for their other TIN/NPIs not affiliated with their APM entity. The agency should increase its outreach and education to ensure all Advanced APM participants are fully aware and understands the implications of this policy.

Marginal Risk

Currently, CMS has applied the marginal risk requirement so that a payment arrangement must exceed the marginal risk rate of 30% at all levels of total losses for Other Payer Advanced APMs. The agency believes that this policy incorrectly categorizes other payer arrangements as not Other Payer Advanced APMs even though they include “strong financial risk components and well exceed the 30% marginal risk requirement at the most common levels of losses in excess of expenditures, and employ marginal risk rates below 30% only at much higher levels of losses.” As a result, beginning in performance year 2020, CMS is proposing to use an average marginal risk rate for APMs with various levels of risk to determine if the marginal risk requirement of 30% is met for Advanced APM purposes.

TMA believes that by using the average marginal risk rate for APMs with various levels of risk, this proposal would raise the threshold for APMs qualifying as Advanced APMs, and therefore decrease the ability of physicians to achieve the 5% Advanced APM bonus. TMA reminds CMS that the Other Payer Advanced APM option was developed to help physicians meet their thresholds and other criteria to qualify for the Advanced APM bonus. We are concerned that this proposal would create a punitive “gotcha system” that would leave many physicians, yet again, not fully understanding their options when they do not qualify for the Advanced APM bonus and thus result in the 9% payment penalty.

Recommendation: CMS should not change the requirements for marginal risk for the Other Payer Advanced APM pathway. The agency should increase its outreach and education to ensure all Other Payer Advanced APM participants are fully aware and understand the implications of this policy.

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 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.