C. ICRs Regarding Quality Performance Reporting Category and Previously Approved Under PQRS

CMS discusses the information requirements for eligible clinicians who are not APM participants. They estimate that 703,467 MIPS-eligible clinicians will submit quality data to the quality performance category. They assume those that submit through claims, QCDR, EHR, and CMS Web Interface for PQRS will continue to do so for MIPS. For MIPS-eligible clinicians or groups, the burden associated with the requirements of the MIPS quality performance category is the time and effort associated with MIPS-eligible clinicians identifying applicable quality measures, collecting the necessary information, and reporting the information. This will vary between practices. They estimate a total of 6 hours as the amount of time needed for a MIPS-eligible clinician's billing clerk to review the measures list, review the submission options, select the most appropriate submission option, identify the measures they can report on, review the measures, and incorporate the submission of selected measures into the workflow. (6 hours x $34.20=$205.20.) They also estimate it will take 1 hour of physician time to review this process. (1 hour x $182.46= $182.46).

AAFP Response

Though CMS does not request comments on this section, the AAFP is compelled to remind CMS that not all physician practices, specifically small practices, have a "billing clerk." The work described most often falls to a physician. Therefore, the AAFP disagrees with the projected financial assumptions. In these practices, the activities assigned to the "billing clerk" will fall to the physician, which changes the assumption to have a higher-cost impact. Also, physicians will likely need more than one hour to review the measures in order to understand their specification, evaluate their current practice as it applies to the measure, and plan anticipated changes in practice. In addition, what is not figured into these projections is the "ramp up" of education needed for office staff and clinicians to understand this overly complex program. Also omitted from consideration of burden was the building of specifications into the EHR system to capture the measure numerator and denominators. This could take hours for each measure and could require, for most, the hiring of an outside consultant. At minimum, it would require negotiation with the EHR vendor. The AAFP reiterates that small practices function differently than larger health systems. The functions carried out by ancillary staff in a health system are often handled solely by a physician in a small practice. Thus, for small practices with a lean staff, the estimates made here are very low and most be reconsidered.

We appreciate the opportunity to comment on this proposed rule and make ourselves available for any questions you might have. Please contact Shawn Martin, Senior Vice President for Advocacy, Practice Advancement and Policy at smartin@aafp.org or 888-794-7481 ext. 2500.

Sincerely,

Robert L. Wergin, MD, FAAFP
Board Chair