Quality Payment Program Recommendations

Merit-based Incentive Payment System (MIPS)

Establish a more gradual transition period: The Medicare Access and CHIP Reauthorization Act (MACRA) provides flexibility to the Centers for Medicare & Medicaid Services (CMS) in how it structures the MIPS program for 2017 and 2018. CMS has limited this flexibility to 2017 without providing guidance for what will occur in future program years. CMS should take advantage of this flexibility and adopt a similar transition year for 2018 to allow physicians to become more familiar with the program and keep program requirements stable.

Promote successful participation: CMS can set the MIPS performance score threshold to promote successful participation by ensuring a greater number of physicians are held harmless from penalties. Specifically, the agency should be flexible about the data used to set performance and should maintain a substantial low-volume threshold that exempts physicians with few Medicare patients or little revenue.

Simplify MIPS Scoring: The MIPS program establishes a complex scoring system that requires physicians to understand numerous point systems, benchmarks, thresholds, case volumes and other calculations to determine their performance. To avoid creating confusion, CMS could simplify the scoring in a number of ways, including defining what must be reported to avoid a penalty, earn a bonus and earn a maximum incentive payment (similar to the approach taken in pick-your-pace) and harmonizing the scoring requirements across MIPS categories. CMS should also consider developing tools that physicians could use to help predict their score with examples tailored to the type of practice and specialty. Lastly, physicians should receive timely feedback so that they can assess their performance and plan for future reporting periods.

Quality

Maintain the reporting thresholds: The 2016 MACRA Final Rule increased the thresholds for reporting on quality measures from 50 percent of Medicare Part B patients to 60 percent of all patients starting in 2018 and indicates increased thresholds in future programs year. Instead of increasing the thresholds, the AMA urges the Administration to reduce the reporting burden and maintain the threshold at 50 percent.

Maintain a minimum 90-day reporting period: Allow physicians flexibility to report for 90-days to a full year in order to receive full credit for reporting a measure under the quality performance category.

Maintain minimum point floor for reporting on measure(s): Allow physicians to receive a minimum number of points for reporting on a quality measure at the reporting threshold, regardless of performance on the measure or the measure type.

Reduce the number of required measures to three: With six required quality measures, the category remains too high and administratively burdensome.

Eliminate administrative claims population health measures: CMS finalized the hospital developed All-Cause Hospital Readmission measure that was part of the value-based modifier (VBM) and incorporates this measure into the MIPS quality category. The measure was developed and tested for use at the hospital-level and has low statistical reliability when applied at the individual physician level, and even at the group level.

Allow specialties to exercise flexibility and innovation in Qualified Clinical Data Registries (QCDRs): Specialties are spending millions of dollars to improve the quality of care for Medicare beneficiaries by creating QCDRs. CMS' requirements for QCDRs, however, are making the registries less innovative and meaningful. CMS should allow QCDRs to adopt measures that vary from those in PQRS in order to provide meaningful measurement for physicians in all specialties.

Eliminate the requirement of end-to-end reporting to receive bonus points: In order to receive bonus points for reporting through the EHR, clinical registry, qualified clinical data registry (QCDR) the data must meet CMS' definition of 'end-to-end reporting". The definition is not realistic because registries and EHRs are not interoperable with one another and if interoperable it is cost-prohibitive. Physicians should just receive bonus points for reporting through the EHR, clinical registry or QCDR and not have to meet the definition of 'end-to-end reporting', which would further encourage electronic reporting.

Eliminate requirements to report one outcome or high priority measure: Under the quality scoring methodology, physicians are at a disadvantage if there are not truly relevant outcomes or high priority measures available to them. Therefore, rather than mandating the use of these measures, CMS should replace the current policy with one that allows physicians flexibility while still rewarding them for using outcome or high priority measures where possible. Specifically, physicians should be allowed to use outcome and high priority measures to meet the six-measure reporting requirement and/or to acquire bonus points by reporting these measures in addition to the required six.

Allow specialty societies the opportunity to determine when a measure is relevant to their specialty: Frequently physicians are required to report on measures that are arbitrary and are not clinically relevant to their practice. CMS should collaborate with the AMA and other medical groups to develop a process to replace the Measures Applicability Validation process which accurately evaluates whether a physician should be required to report certain measures.

Improve transparency around "topped out" measures: Currently, if a physician reports on a topped out measure, they do not receive the same amount of points as those reporting on non-topped-out measures. To simplify reporting and reduce physician's administrative burden, reporting on a topped-out measure should have the same number of points as non-topped out measures. If CMS retains its "topped out" quality measure policy, CMS must identify measures it considers "topped out" in advance of the reporting period and publish the information in a transparent manner. This includes information on the measure benchmark, as well how reporting on a topped out measure may impact a physician's score.

Release MACRA measure development funding: Key to achieving the goals of MACRA is the availability of an adequate portfolio of appropriate quality measures. MACRA specifically authorizes $15 million per year for each of fiscal years 2015 through 2019, for a total of $75 million, to fund the development of physician quality measures for use in MIPS. We recommend any funds go to physician-led organizations, such as medical societies and the PCPI and not be provided to contractors that lack sufficient physician input.

Cost

Keep the cost category's weight in the composite score at zero in 2018: In the final MACRA rule, CMS set the weights at zero in year one and 10 percent in year two. There are tremendous problems with the various methodologies, such as risk adjustment and attribution. CMS' own data has shown that the current methodology discriminates against physicians who treat the sickest patients. The agency needs time to develop better risk adjustment and attribution. CMS clearly has the statutory authority to reduce the second year weight to zero.

In years three through five create and expand a pilot program: In the pilot, the cost score would be calculated only for physicians who volunteered to test new measures that are based on episodes of care, adjust costs to reflect patient condition, and use patient relationship categories to attribute costs within the episodes.

Meaningful Use/Advancing Care Information (MU/ACI)

Maintain a 90-day reporting period: Sufficient data on technology use can be collected and evaluated in a shorter and more efficient 90-day reporting period. Beginning in 2018, the full year reporting period requirement is too burdensome and does not allow physicians the necessary time to test, upgrade, and replace their systems.

Remove mandate to update versions of Electronic Health Records (EHRs): By 2018, physicians will be required to purchase a new EHR version despite the fact that most of these products are still under development and benefits of the new technology are not yet realized. We urge CMS to allow physicians to keep their existing EHRs until new products are ready for deployment.

Avoid a one-size-fits-all approach: CMS has maintained a pass-fail approach to some of the ACI/MU measures. More flexibility is needed in the base ACI score to allow physicians to receive credit for individual base measures. Additionally, the base and performance scoring should be reweighted to encourage proficiency in the base measures and account for physicians' lack of control over patient-dependent performance measures (e.g., Base is 75% and Performance is 25% of ACI). Physicians should be allowed to engage with technology in ways that best benefit their patients and should not fail a program for missing measures that are not relevant to their practice. CMS should encourage new measures to promote physician and patient engagement with technology.

Avoid duplicative reporting on technology: The MU/ACI program has now been divided depending on if you have Medicare or Medicaid patients or if you work in a physician office vs. a hospital setting. Few will understand the different requirements and may end up reporting twice. CMS should therefore allow reporting on MU to count for ACI and vice versa.

Expand facility-based exemptions: CMS currently offers an ACI exemption to hospital-based physicians. It should create a similar exemption for physicians practicing in other types of facilities with little experience in MU/ACI measures (e.g, long-term post-acute care). We also urge CMS to issue its hardship exemption applications as soon as possible so that facility-based physicians will know ACI will factor into their 2017 MIPS score.

Improvement Activities (IA)

Allow flexibility in performing activities: CMS intends to issue more detailed guidance about the Improvement Activities component of MIPS. Currently, the requirements for most IAs are extremely vague. Such guidance should be broad and not overly stringent to ensure maximum participation by physicians.

Avoid complex reporting requirements: MACRA intended the IA component of MIPS to provide credit for ongoing or already established activities. Physicians should therefore be able to continue to report through attestation. CMS should not add future lengthy documentation or other submission requirements that will increase administrative burden.

Create stability in program requirements: The IA component is a new aspect of physician evaluation. As such, the administration should refrain from imposing more stringent requirements on scoring in future years. In addition, the administration should permit—and even incentivize—physicians to perform the same activity over multiple years in order to effectuate change over the long-term. To this end, the

administration should ensure that IAs will not be removed from the list of approved activities without notice and comment.

Increase the weight of the IA category: MACRA offers flexibility by allowing the Secretary to reweight the MIPS components if there are not sufficient measures and activities applicable and available to a participant. Non-shared savings program MIPS APMs do not receive a score in either the quality or cost categories. As a result, CMS used its authority to reweight the ACI and IA categories to 75 percent and 25 percent, respectively. This policy places too much emphasis on a single category and is counter to CMS' intent to create a program that harmonizes the different MIPS components. We recommend that CMS increase the IA category weight to reduce this disparity (e.g., 60 percent for ACI and 40 percent for IA). A similar reweighting should be applied to physicians practicing in medical homes due to the significant emphasis of medical homes on activities that promote patient-centered, comprehensive, coordinated, accessible, and safe care, as well as to facility-based physicians who help implement hospital quality improvement initiatives.

MACRA Alternative Payment Models (APMs)

Do not increase the current nominal risk threshold: The Final Rule allows APMs to meet the MACRA standard for "more than nominal financial risk" if they risk losing 8% or more of their revenues, instead of tying risk of losses to total costs. This option is especially important for physician-led APMs because physician services are only a small proportion of total costs. The final rule said that CMS plans to raise the percentage above 8% in 2019, potentially increasing it to 15%, but instead it should preserve stability and predictability for APMs by maintaining the current 8% threshold. CMS should also extend this option to Other Payer APMs, not just Medicare APMs, to encourage multi-payer models.

Increase flexibility for medical home models: CMS rules allow primary care medical home models to qualify as Advanced APMs using a lower standard for financial risk than other APMs. After 2017, however, CMS proposes to allow this lower standard only for medical homes with fewer than 50 clinicians. This limitation should not be imposed. In addition, specialty medical homes should have access to the same financial risk standard as primary care medical homes.

Increase opportunities for physicians to succeed in MIPS through APM participation: There are very few APMs that CMS counts as MIPS APMs, which compounds the problem of having so few Advanced APMs. Physicians participating in models like Bundled Payments for Care Improvement and Independence at Home should be able to use their participation for IA credit in MIPS.

Adopt physician-focused APMs: Armed with the right data, physicians can see where the best opportunities are to improve the delivery of care and reduce avoidable spending. CMS should work with the physician community and the Physician-focused Payment Models advisory committee (PTAC) to implement physician-focused APMs, including providing technical assistance and data, and allowing small numbers of practices to pilot innovative models.

Interoperability

Increase the transparency around EHR costs: Physicians have already made significant investments in their EHRs, yet vendors often require additional, yearly fees to connect those EHRs to registries, information exchanges, and public health agencies. The Office of the National Coordinator for Health Information Technology (ONC) already requires vendors to state extra charges may be required; however, the dollar figures are not made public. Most EHR vendors overly generalize costs and are not upfront

with physicians when selling their products. This drastically affects small and solo physician offices. These fees are often both a surprise and overly excessive—acting as a roadblock to the exchange of vital patient data while limiting the interoperability between EHRs. Vendors seeking ONC certification should publically provide detailed examples of fees (including dollar figures) typically charged to physicians to enable data sharing.

Prohibit vendor data blocking: While CMS' implementation of MACRA requires physicians to attest to a multipart attestation on data blocking, vendors currently do not face any limits on data-blocking activities. In the vast majority of cases, the vendors implement cost, technical, or contractual limitations to block the flow of patient data. ONC should take immediate actions to implement a vendor data-blocking attestation requirement as part of all current and future health information technology certification editions.

Refocus ONC's Certification Program: ONC certifies that EHRs are able to meet a low-bar of requirements directly attached to CMS' reporting program. This has led to the unintended consequence of forcing vendors to build EHRs that accommodate federal government requirements and incentivizes vendors to ignore physician and patient needs. ONC should refocus its certification program to test and validate an EHR's ability to conform to features, functions, and capabilities described and sold by the vendor and should reflect the real-world needs of patient care.