Proposed 2019 Medicare QPP rule: Top 7 things doctors should know

Physicians have weighed in on the Centers for Medicare & Medicaid Services' (CMS) plans to modify the Quality Payment Program (QPP) that is intended to transform the Medicare payment system by linking payment updates to physicians' efforts to improve quality of care, reduce health care spending and participate in alternative payment models. The AMA is calling on CMS to cut red tape that makes it difficult for physicians to succeed in QPP.

The comments on QPP came as part of a broader, 136-page letter (PDF) that also addresses CMS' proposed changes to the 2019 Medicare physician fee schedule. These detailed comments on the rule elaborate on an earlier letter in which the AMA was one of 170 organizations representing physicians and other health care stakeholders that objected to the CMS plan to collapse payment rates for physician evaluation-and-management (E/M) office visit services over concern about its potential impact.

“This provision in the proposed rule should be filed under the category of unintended consequence—or good intentions that go awry," AMA President Barbara L. McAneny, MD, said of the E/M proposal."

On the QPP portion of this 1,500-plus page rule, here are seven things that physicians should know about the changes that CMS should make to its proposed rule.

Make virtual groups more viable. Given the small number of virtual groups participating in the Medicare-based Incentive Payment System (MIPS) program in 2018, CMS should implement additional changes to make this a more viable option for physicians in small practices.

Simplify MIPS scoring. The MIPS program should be improved to make it simpler and allow physicians to spend less time on reporting and more time with patients, but the CMS proposal did not move toward a more simplified scoring methodology. One area where the program could be significantly simplified is in the scoring used for each performance category to calculate a physician's final score. The AMA proposed a simplified scoring methodology that CMS should immediately
implement.

**Performance threshold and weights for MIPS categories.** CMS should avoid raising the performance threshold, changing the category weights and removing quality measures, when there is no MIPS data to analyze. Decisions are being based on hypothetical assumptions from legacy programs such as the Physician Quality Reporting System. MIPS is a separate program with its own set of rules and requirements.

**Reduce the required number of measures a physician must report under the Quality category.** To immediately cut red tape and administrative burden, CMS should reduce the number of quality measures a physician must report under the Quality category. Without such a reduction, the AMA does not support immediate removal of the proposed measures but would support a modified phased approach to the topped out measure process.

**Retain flexibility in Cost category.** CMS should not increase the Cost category weight from 10 percent to 15 percent and should remain flexible on weights for the next four years while the eight new episode-based cost measures are evaluated and more are developed and piloted. Several other provisions in the proposed rule are also objectionable because, in its desire to "capture more physicians in the cost category," CMS is undermining the reliability of and confidence in the measures.

**Simplify requirements in the Promoting Interoperability (PI) category.** CMS’ overhaul of the Advancing Care Information category is laudable, as are many of the proposals within the renamed PI category. CMS should continue to limit regulatory requirements, including aligning the PI programs so that physicians must only achieve the same score as hospitals to receive full PI category credit, simplifying and reducing burden through Yes/No measure attestation, and scoring PI on the objective-level.

**Move ahead on alternative payment models (APMs).** CMS should finalize several of the proposed policies for APMs, such as the move to maintain the revenue-based financial risk requirement at no more than 8 percent for another four years. The agency should also raise the availability of well-designed APMs under the QPP.

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