Aug. 24, 2017: Advocacy spotlight on QPP rule should be simpler, more flexible

QPP rule should be simpler, more flexible

On Aug. 21, the AMA submitted a comment letter (PDF) to the Centers for Medicare and Medicaid Services (CMS) on the Quality Payment Program (QPP) proposed rule for 2018. The comments reflect input from the Federation through both the Merit-based Incentive Payment System (MIPS) and alternative payment model (APM) workgroups.

The letter expresses appreciation for many CMS proposals that address AMA concerns, especially the need for another transition year in 2018 and additional assistance for small and rural practices. Nonetheless, it urges CMS to simplify, provide flexibility, and streamline the program and makes specific suggestions for how to accomplish these goals. The AMA will also continue emphasizing the need to reduce regulatory burden and simplify the QPP in its ongoing dialogue with the agency on this program.

Positive elements of the proposed rule include that it:

- Makes 2018 another transitional year and raises the low-volume threshold exemption to $90,000 or 200 Medicare beneficiaries.
- Initiates virtual groups to enable small practices to combine resources for reporting under MIPS without formally integrating.
- Helps small practices with an exemption from the advancing care information (ACI) component of MIPS and additional bonus points.
- Postpones the mandate for physicians to upgrade to 2015 certified Electronic Health Record technology (CEHRT).
- Maintains rather than increases current requirements for the number of quality measures and data completeness.
- Keeps MIPS cost category’s weight at zero in 2018.

There are issues with the proposal, however, that CMS should address in the final rule. The AMA is urging the agency to:

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Set the composite score performance threshold at six rather than 15.
Exclude Part B drugs from MIPS calculations or payment adjustments.
Simplify the scoring methodology.
Provide timely notification to practices that qualify for special exceptions and treatment.
Ensure methodology and data are sound before scoring practices on data reporting improvement.
Provide maximum flexibility for virtual groups.
Modify quality provisions on topped-out measures and benchmarks and eliminate requirements related to outcome measures, all-payer data and administrative claims measures.
Finalize the zero cost weight for 2018 and keep weight low in next three years.
Add flexibility to the ACI category, reduce data blocking attestation requirements, and grant physicians ACI credit for using CEHRT to participate in qualified clinical data registries.
Refrain from adding complexity to the improvement activity category.
Phase in and then retain the 8 percent revenue-based nominal risk standard for APMs for the foreseeable future.
Extend the medical home risk standard to small and rural practices participating in all advanced APMs.
Include medical homes comprised of specialty practices.

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