TEXAS MEDICAL ASSOCIATION

IMPROVING AND SIMPLIFYING THE MEDICARE QUALITY PAYMENT PROGRAM

Recommendations to Support Physicians in Their Move to Value-Based Care and Alternative Payment Models

April 2018

Vision: To improve the health of all Texans.

Mission: TMA stands up for Texas physicians by providing distinctive solutions to the challenges they encounter in the care of their patients.

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Summary of TMA Recommendations

- **Base physician fee updates, like those for hospitals and other Medicare providers, on the market-basket inflation measures that estimate the annual increases in the cost of production**
- **Increase physician fee updates immediately and eliminate the future planned inequitable updates that discriminate against small physician practices**
- **Do not use the update as an imprecise tool to try to limit physician treatment decisions**
- **Improve and simplify the Quality Payment Program and make participation voluntary**
- **Eliminate payment penalties and budget neutrality**
- **Abandon burdensome requirements for electronic health records**
- **Enhance interoperability of health information technology**
- **Use quality and cost metrics that capture only what is under physician control**
- **Remove requirement for downside risk to earn incentives in the Alternative Payment Models track**
- **Provide more education and technical assistance to support physicians in their move to value-based care and alternative payment models**

I. Introduction

Background

The enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is one of the biggest drivers in the push from fee-for-service to value-base care.[1] Title I of the law, which garnered widespread bipartisan support, was monumental in its passage as it repealed the Sustainable Growth Rate (SGR) formula used to control Medicare spending and determine physician fee schedule updates. In addition, Title I streamlined burdensome, costly, and complex quality reporting programs that the Centers for Medicare & Medicaid Services (CMS) imposed on physicians. It also established two new tracks for Medicare payment: the Merit-Based Incentive Payment System (MIPS) and alternative payment models (APMs).[2]

These two tracks present a new approach to Medicare payment that focuses on the quality and value of care delivered. To implement them, CMS created the Quality Payment Program (QPP), which consists of integrated Medicare policies in which eligible physicians participate in an advanced APM, default to the MIPS track, or face automatic, per-claim pay cuts under the Medicare physician fee schedule. Data submitted for a given performance year affect Medicare payments two years later. Pay cuts start at 4 percent in 2019 and increase until they cap at 9 percent in 2022 and beyond. The first QPP performance year began in 2017, affecting Medicare payments in 2019.

However, barely into the second year of MACRA implementation, the Medicare Payment Advisory Commission (MedPAC) recommended in February of this year that Congress eliminate MIPS and replace it with an entirely new program.[3] Contemporaneously, the U.S. Department of Health and Human Services (HHS) released the President's Fiscal Year 2019 Budget Request, which included recommendations to simplify the QPP.[4]

In this document, the Texas Medical Association (TMA) summarizes key events surrounding MACRA implementation (see Appendix), outlines our concerns with physician fee schedule updates and the QPP, and presents a brief analysis of the proposals by MedPAC and HHS. Most importantly, we offer recommendations to support physicians in their move to value-based care and APMs. The recommendations focus on improvements to fee schedule updates; QPP participation, technology and data requirements; APMs and advanced APMs; and related QPP components.

II. Physician Fee Schedule Updates

MACRA embodied a long-sought victory for organized medicine due to the repeal of the SGR. That highly flawed formula was enacted under the Balanced Budget Act of 1997 and posed annual threats of deep cuts to physician payments every year since 2001. Although the permanent repeal of the SGR prevented an estimated 21-percent cut to Medicare fees in 2015, MACRA unfortunately failed to create a sustainable physician fee schedule. Instead of implementing inflation-based fee updates similar to those in place for facilities, MACRA promised fee increases of 0.5 percent for five years, not an adequate amount to cover practice cost increases that historically have averaged 2 percent per year. Even those inadequate fee updates have not materialized because MACRA did not address some contradictory provisions of prior legislation, as documented in the timeline in the Appendix.

The most critical issue for physicians lies in an analysis of the future of Medicare payment, which demonstrates that the currently budgeted physician fee schedule updates, when adjusted for general inflation, result in continuous decreases in Medicare fees paid to physicians. Unfortunately, this declining fee adequacy is a continuation of a long-term trend that started in 1992 with physician fee schedule updates using the Volume Performance Standard[5] and continued with the SGR methodology. Both of these formulas were designed, with slightly different methodologies, to cut physician fees in response to increases in Medicare utilization. This stands in stark contrast to the fee updates for hospitals and other Medicare providers that are calculated based on an estimate of market-basket cost increases. The result, when adjusted for inflation, has been continuous cuts to physician fees and growing inequity in the financial adequacy of Medicare payment. Figure 1, calculated from CMS fee update information[6] shows the compounded effect since 2001.

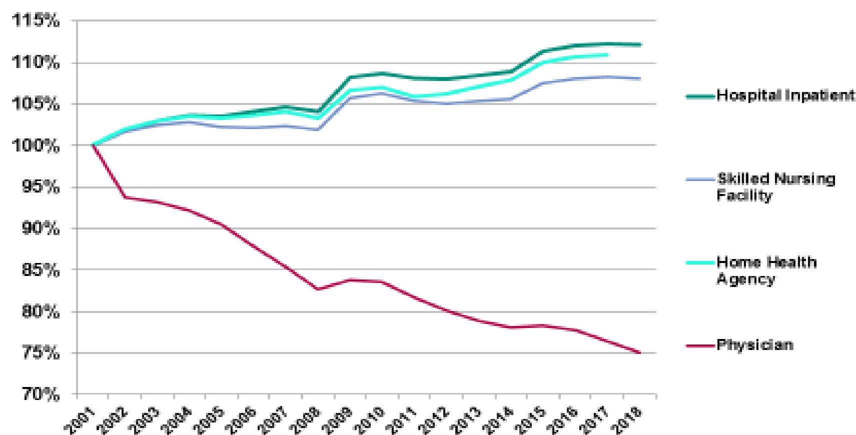
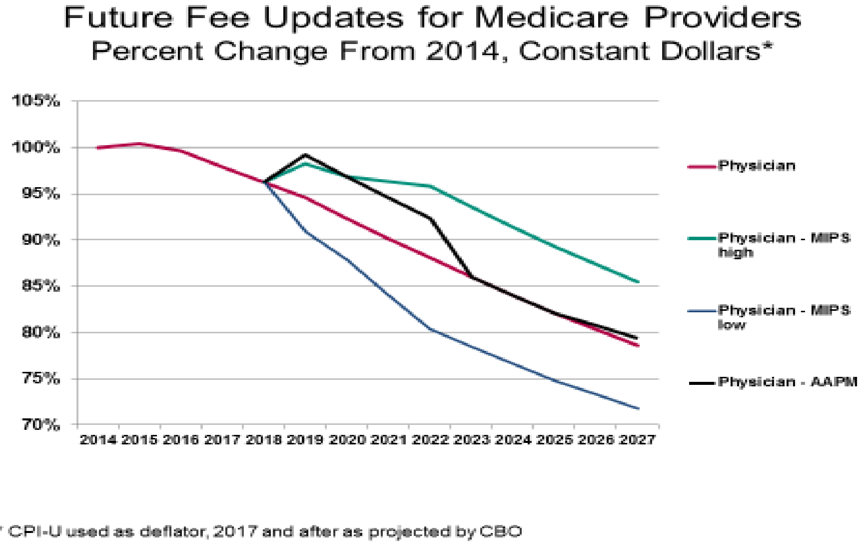


Figure 1. Comparative Fee Updates for Medicare Physicians and Providers

While hospitals, nursing homes, and other Medicare providers get annual fee updates based on increases in the cost of providing services, physicians have been subject to flawed fee schedule update formulas since 1992 and continue to face updates that are far less than the rate at which their costs are increasing. The compounded results mean that physician payment in constant dollars is currently 25 percent below 2001 levels. This is not competitive in the commercial marketplace. According to MedPAC, by 2014, Medicare physician fees were 22 percent below the prices paid by commercial insurers.[7] The currently budgeted payment formulas will erode payment adequacy even further as general inflation returns to historical levels.

Although MACRA has created programs that allow physicians to receive slight increases or decreases relative to the standard fees, the future trajectory in payment for all physicians is continuing declines in compensation for services to Medicare patients. Figure 2 shows the net future effect. General inflation (measured by the Consumer Price Index-Urban Consumers) is expected by the Congressional Budget Office to average more than 2 percent per year. Historically, Medicare has calculated the Medicare Economic Index to average 2 percent per year, even while including a flawed productivity offset. Physicians, however, are currently budgeted to receive updates at 0.5 percent until 2019, zero percent from 2020 through 2025, and variable amounts less than 1 percent thereafter. As a result, all physicians will continue to experience declines in Medicare payment adequacy. The small upwards or downwards fee adjustments available via the MACRA QPP will induce very minor variations on this major trend, but the cost of QPP compliance will exacerbate the stark contrast between cost and revenue. In the APM track, there is no realistic possibility that shared savings can increase continuously year over year in amounts sufficient to offset this major trend.

Figure 2. Future Fee Updates for Medicare Physicians and Providers



Starting in 2026, physicians are scheduled for a split update, with a larger, though still inadequate, update being offered to groups that accept risk-based payment. Because physicians in small practices cannot reasonably accept risk due to the statistical volatility of small numbers, the split update will selectively favor large physician practices and punish physicians who practice in small businesses, including many in nonurban or rural locations. Based on TMA's 2016 Physician Survey, 73 percent of Texas physicians work in practices of eight or fewer physicians.[8]

Increasingly inadequate Medicare payments to physicians have spurred a constellation of effects, including closures of small physician practices, increases in hospital employment of physicians, and physicians intentionally limiting their acceptance of Medicare patients. In Texas, 37 percent of physicians now refuse or limit new Medicare patients.[16] All of these effects have the potential to limit the access of Medicare beneficiaries to medical care. Limits on access to good ambulatory care will lead to increasing costs as more care is delivered in hospital emergency departments or as inpatient care. As physicians lose financial and clinical autonomy, the quality of patient care is also threatened. Physicians are legally and ethically bound to serve patients in ways that hospital administrators are not. Ensuring that physician decision-making is independent and not restricted by hospital employers would serve the best interests of patients.

The long-term historical strategies to limit physician fees have been based on the flawed premise that cutting payments to physicians would be an effective method to limit overall Medicare spending growth. The underlying assumption has been that medical cost growth is driven by physician actions and choices, and that those choices could and should be affected by the blunt tool of punitive price controls. The continuing growth in total Medicare costs should be evidence that that strategy has been ineffective. Efforts to control utilization growth must be targeted more precisely to be effective and must consider all the factors that drive growth. These include new treatments and technologies, changes in patient expectations, the underlying health and socioeconomic status of the community, patient demand for care, and expansions in Medicare coverage. Continuing to use the imprecise and failed tools of the past is not likely to suddenly

yield the desired result. In fact, the best prospect for limiting total Medicare cost requires increases in spending on outpatient ambulatory care that leads to continuing reductions in the use of costly inpatient services.

Physician fee updates, like those for hospitals and other Medicare providers, should be based on the market-basket inflation measures that estimate the annual increases in the cost of production. The updates should be increased immediately, and the future planned inequitable updates that discriminate against small physician practices should be eliminated. In summary, the update should no longer be used as an ineffective tool to try to limit physician treatment decisions.

III. Quality Payment Program Issues

Paying for Value

In designing a program to pay for value, the goal is to reduce cost while maintaining or improving quality. Since Medicare is a price-controlled system, incentives to reduce cost are actually incentives to reduce utilization or to replace utilization of high-cost services with low-cost services. Systems designed to reduce cost or utilization without good methods for monitoring quality would create incentives to withhold services without regard to their value or necessity, and disincentives to treat patients who need more or costlier care than is typical for others with the same diagnosis. Accurate and relevant quality measures are necessary to ensure that reductions in utilization do not result in poor quality or outcomes.

Unfortunately, both cost and quality measures, as currently implemented, result in serious attribution problems, so that physicians frequently are assigned responsibility for cost or outcomes that are unrelated to any care that they have provided. It is not meaningful, for example, to hold a physician responsible for a high-cost hospitalization due to an automobile accident simply because the patient had visited that physician for preventive care at some time in the same calendar year. Similarly, a physician who measures and reports a good blood pressure reading is not necessarily the physician who should be given credit for that outcome. When cost and quality are measured with the imprecise tools that are currently used, rewards and penalties are often attributed incorrectly.

Furthermore, it is currently not possible to accurately measure all aspects of care quality. While some existing measures may very accurately assess some specific features of care quality, they are not comprehensive. Some measures may be so strongly affected by factors other than health care inputs, that they actually are poor measures of physician care quality. In fact, both cost and quality outcomes are likely to be affected by patient-specific attributes such as poverty, educational attainment, family support, and the ability and willingness to comply with physician treatment recommendations.

According to Richard "Buzz" Cooper, MD, in *Poverty and the Myths of Health Reform*, payment systems must be properly risk adjusted for the population served so that physicians are not penalized for taking care of low-income, high-risk patients.[9] Presently, because MIPS does not properly risk adjust for socioeconomic factors and the social determinants of health, physicians whose practices are located in high-poverty communities or who treat high-need or non-

compliant patients will be profiled adversely and underpaid. Unless cost and quality measures are properly risk-adjusted, they should not be used to reward or penalize physicians. This also means that those measures should not be used when sample sizes are too small for accurate risk adjustment.

In addition to these systemic measurement problems, significant administrative and cost burdens and other challenges continue to impede physicians from transitioning from fee-for-service to value-based care. Many of CMS's policies and QPP requirements further compound these problems and are contributing to increasing rates of stress and physician burnout. Surveys continue to show that physicians report heavy regulatory, administrative, and cost burdens leading to increasing levels of stress and burnout, as high as up to 50 percent in some studies.[10]

MIPS

TMA believes MIPS is burdensome and complex and that data collected under current methodologies will not be useful in detecting high quality and low-cost care. Thus, there is insufficient justification for the complex payment system. The following is a summary of current CMS MIPS policies and other challenges that add to physician burden:

- A 2016 study by the U.S. Government Accountability Office showed that physicians in small and rural practices face many challenges with value-based care models. The study revealed that small and rural practices experience challenges with financial resources and risk management, health information technology and data, population health management, quality and efficiency performance measurement and reporting, and effects of model participation and managing compliance with requirements.[11] CMS therefore should make MIPS voluntary and create policies that support physicians as they transform their practices rather than subject them to a punitive program because they do not have the practice and clinical systems in place now to compete against larger group practices.
- The 2016 TMA Physician Survey showed that 76 percent of Texas physicians now use an electronic health record (EHR).[12] However, physicians do not like having to click boxes for the sake of MIPS or other programs that in their view do not improve quality of care or that they do not find meaningful to their specialty, practice setting, or patients. As CMS seeks to reduce administrative burdens, TMA supports eliminating arbitrary EHR requirements.
- Physicians collect and report MIPS data via multiple data submission mechanisms, taking time away from clinical care. In a study published in the *Annals of Internal Medicine* in 2016, researchers found physicians spend 49 percent of their time on EHR and desk work.[13] Because physicians entered medicine to help patients, anything getting in the way of that should be the focus of change.
- Success in meeting MIPS requirements depends upon certified EHRs and the ability to exchange health information securely, which requires bidirectional interoperability. Physicians making a good-faith effort to improve practice efficiencies and clinical workflows, while trying to meet MIPS requirements, often must work with costly EHR technology that is not sufficiently standardized for usability and patient safety. Data mapping for interoperability varies by vendor, which translates to costly interfaces and maintenance.[14]
- TMA remains concerned about interface connection and maintenance fees that EHR vendors charge to physicians. For many years, TMA has advocated for universal use of extensible

markup language or a similar standard (e.g., FHIR) to exchange meaningful health data, as is used in accounting and other industries. Universal common encoding of all data elements could permit disparate systems to share and consume information much more easily. CMS, the Office of National Coordinator for Health Information Technology, and the National Institute of Standards and Technology should work together to create standards for safer, faster, and affordable sharing of health data.

- Physicians need assurance that data systems that contain their patients' personal health information are secure. As patient health information leaves the practice, physicians lose control of the movement of that data; yet as the source, they still retain responsibility. CMS should ensure interoperability is secure and take a greater role in cyber security.
- MIPS compliance, documentation, data collection, and reporting requirements are prohibitively expensive. A 2016 study in the journal *Health Affairs* found annual costs of more than $15 billion to comply with quality reporting requirements.[15]
- MIPS program compliance efforts are cost-effective only for large groups, effectively forcing small, private practices to merge with larger health care organizations. Studies show less competition and increased hospital ownership of practices leads to higher health care costs. One study, conducted by researchers at the University of California, found average expenditures per patient were 10 percent higher for hospital-owned practices and 20 percent higher for health system-owned practices compared with those owned by physicians.[16]
- MIPS offers multiple measures, reporting options (claims, registry, qualified clinical data registry, EHR, web interface) and different benchmarks. This can cause physicians to be scored differently depending on the measures and reporting option selected. Because of all the complexity in each MIPS category, it is unlikely physicians will understand their score or how to improve it.
- For most physicians, MIPS quality measures apply only to a subset of their patients, which may be too small for any statistical reliability. Furthermore, TMA has heard from many physicians who do not find MIPS quality measures meaningful to their practice or who cannot find applicable measures.
- Performance on MIPS measures often is impacted by social determinants of health, which are not in a physician's control. Some sources have estimated that clinical care, which includes quality of care, contributes as little as 10 percent to health outcomes and that behavioral causes account for nearly 40 percent of all deaths.[17] The current MIPS program does not use adequate coding or risk adjustment to neutralize these impacts.
- Physicians who care for specific patient groups will be penalized unfairly under MIPS. Worse, the current incentive systems create an environment where social determinants of health can make certain patients undesirable. Incentives must be redesigned to avoid those results.

Additionally, MIPS as currently designed is a pay-for-performance (PFP) program. TMA's longstanding policy regarding PFP programs includes, in part, the following principles:[18]

- Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality-of-care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.

- Fair and ethical PFP programs support the patient-physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment patterns.
- Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of nonparticipating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

TMA believes that MIPS does not meet these principles of a fair and ethical PFP program. MIPS adds a significant economic burden on physician practice and does not accurately identify high-quality care provided by physicians. TMA recommends CMS replace MIPS reporting requirements and payment adjustments with a program that is truly voluntary. The program should not impose penalties on physicians. Measures should align across private payers and programs to prevent further administrative and cost burdens for physicians.[19] Physician performance measurement must use relevant, meaningful, and accurate metrics with medically appropriate exceptions and exclusions, including proper risk adjustment to both cost and quality measures to eliminate the impact of social determinants of health and other cultural or socioeconomic variables.[20, 21, 22, 23] Because CMS will start implementing MIPS payment adjustments in 2019, action is needed now to eliminate the perverse incentives and pointless administrative and cost burdens.

APMs

Currently, there are a limited number of advanced APMs, and not all physicians have the opportunity to participate in one, including many physician specialists.[24] TMA believes advanced APMs must be designed to attract physicians to participate voluntarily in programs proven to treat their Medicare patient population effectively. As currently designed, however, APMs do not meet this test and have multiple flaws including:

- APM participation may be too risky for most physicians. While MACRA includes potential financial incentives for physicians to join advanced APMs, those physicians then face financial risk and investments to improve quality and reduce spending, without the guarantee they will meet the required threshold for revenue and patients required in the advanced APM track.[25] This lack of certainty may keep physicians away from advanced APMs.
- The viability and effectiveness of each of the APM models is still uncertain. MACRA does not require that physician-focused payment models be tested long term by CMS to qualify as an advanced APM. The law explicitly states only that HHS shall not require that the model be budget neutral initially and that implementation can continue if the model is expected either to improve the quality of care without increasing spending, reduce spending without reducing the quality of care, or improve the quality of care and reduce spending.[26]
- Other models also are still unproven. CMS needs to carefully study the results of APM model performance to ensure their design does not incentivize cherry-picking of patients or penalize groups that operate in specific geographic areas where patient demographics vary from the average.

To be successful in attracting and maintaining physician participation, it is imperative that advanced APMs be studied long term and be able to demonstrate the model is incentivizing effective and efficient treatment for all patients, including disadvantaged or complicated patient populations and/or those in disadvantaged socioeconomic areas. In these settings, physicians must not be judged solely on the cost of the care they provide but rather on credible, reliable, and understandable clinical measurements of medical practice that contribute to improving quality of care in a cost-effective manner.[27]

Until APM models are tested and proven, we strongly oppose any efforts to require physicians to participate or to penalize physicians who do not participate. APM participation should remain voluntary. Given the existing and future inadequacy of physician fees, TMA strongly opposes using withholds or other fee cuts to fund larger APM incentives.

IV. Analysis of New Proposals

New Proposal by the Medicare Payment Advisory Commission

In MedPAC's recent report on Medicare payment policy to Congress, it concludes that MIPS "will not fulfill its goals and therefore should be eliminated."[28] Instead, the commission recommends a new policy, the voluntary value program (VVP), which includes the following main features:

- Physicians would join an advanced APM, elect to be measured as part of a "voluntary" group, or lose a "withhold." The size of the group would be determined by CMS.
- Voluntary groups would be assessed on a uniform set of population-based measures that align with MedPAC's quality principles.
- Physicians would no longer need to report quality data to Medicare because all measures would be calculated by CMS from administrative claims and patient experience survey data.
- The VVP would require only minimal administrative processes and would entail less risk and reward than is required in advanced APMs.
- Physicians would be eligible to receive an incentive payment or lose a withhold at the voluntary group level. The amount of the withhold would be determined by CMS.
- Physicians who do not participate in an advanced APM or voluntary group would automatically lose the withhold (get a payment penalty).
- The payment system would be budget neutral, meaning payment increases for high-performing voluntary groups would be financed by payment reductions imposed on poorly performing voluntary groups or physicians who do not participate in the VVP.

New Proposal by the U. S. Department of Health and Human Services Department

The recently released President's FY 2019 Budget Request included recommendations to simplify government-imposed physician burdens in Medicare.[29] Among its many recommendations, the budget proposes to eliminate arbitrary requirements for the use of EHRs. The budget also proposes to simplify the QPP and reform MIPS by removing two performance categories and evaluating physician performance based on quality and cost metrics at the group level only.

Similar to MedPAC's proposal, these changes would eliminate the requirement for reporting by physicians, as data would be obtained from administrative claims and patient experience surveys. This proposal would continue to use payment penalties on some physicians to fund incentive payments for others and would retain the $500 million in annual additional performance bonus payments for physicians who achieve high scores. The budget further recommends removing thresholds physicians must meet to receive a bonus in advanced APMs.

In addition, CMS recently delivered testimony on the implementation of MACRA's physician payment policies before the U.S. House Committee on Ways and Means, Subcommittee on Health.[30] As part of its written testimony, CMS included information on the HHS budget's proposals but did not address the likelihood of their adoption or whether the agency would incorporate the policy proposals into the rulemaking process for the 2019 QPP performance year.

TMA Analysis

TMA has analyzed the MedPAC and HHS proposals and has three overarching concerns:

1) Medicare payment would be based, in part, on patient experience surveys known to be flawed[31] and which historically have been optional for physicians in small group practices in CMS's Physician Quality Reporting System, and which remain optional for groups of two or more eligible clinicians in MIPS (yet not appropriate for physician specialists who do not provide primary care services[32]);
2) performance would be based on claims-based quality and cost metrics that would continue to be out of physician control and likely associated with flawed attribution and measurement methodologies; and
3) all physicians would have to participate in an advanced APM, "voluntary" group, or face a payment penalty in the form of a withhold.

TMA believes that data on broad-based quality and cost measures derived from administrative claims are even less likely to produce accurate measurement of the quality and value of care delivered by physicians. If not properly addressed, this will continue to exacerbate the inequitable treatment and assessment of physicians who treat disadvantaged patient populations as previously seen in CMS's Value-Based Payment Modifier program.[33, 34, 35]

It is our assessment that requiring physicians to form voluntary groups as recommended by MedPAC, or to report at the group level only as recommended by HHS, undermines physicians' professional autonomy in designing their care delivery systems for their Medicare patient population. This particular policy would result in physicians having to relinquish control of their own Medicare value-based payments. Given that approximately 73 percent of Texas physicians are in solo or small group practices with eight or fewer physicians, we believe that requiring all physicians to either join an advanced APM or participate in a voluntary group would be a disaster for many physicians in our state.[36]

Based on TMA's analysis, we do not see MedPAC's policy recommendation as a true voluntary program because physicians would continue to be subjected to payment penalties through the form of a withhold for not joining a voluntary group. MedPAC states this particular policy would

allow physicians to get "comfortable with being measured in a manner similar to the way they would be in advanced APMs," thereby assuming all physicians would be willing to join voluntary groups in preparation and/or as a pathway to accepting financial risk in advanced APMs. TMA believes the commission is wrong in this assumption and considers this policy to be excessive government overreach into the private practice of medicine, while also threatening independent practice.

As suggested by industry experts, including Gail R. Wilensky, Ph.D., rather than abandon MIPS, TMA recommends the proposed VVP model be pilot-tested through the Center for Medicare & Medicaid Innovation as an APM with results evaluated before considering the payment system on a national scale.[37]

V. TMA Recommendations to Support Physicians

TMA believes transitioning physicians to yet another new, complex, and untested payment system and requiring physicians to organize into voluntary groups or report at the group level pose serious threats to small and independent practicing physicians in our state. As the QPP advances in its second year of MACRA implementation, TMA urges Congress, HHS, and CMS to further improve and simplify the QPP for both solo physicians and group practices, and establish policies that would facilitate a gradual transition to existing and future APMs. To better support physicians in their move to value-based care and APMs, TMA offers the following recommendations to eliminate or reduce physician burdens.

Physician Fee Schedule Updates

- Increase physician fee updates immediately and eliminate the future planned inequitable updates that discriminate against small physician practices.
- Base physician fee updates, like those for hospitals and other Medicare providers, on the market-basket inflation measures that estimate the annual increases in the cost of production.
- Improve the Medicare fee schedule methodology by making the work GPCI floor permanent to prevent fee cuts to rural physicians, and by requiring CMS to regularly update payment locality definitions that have not been revised since 1996, to eliminate inequities caused by urban growth.
- Do not use the update as an imprecise tool to try to limit physician treatment decisions.
- Given the existing and future inadequacy of physician fees detailed above, do not use withholds or other fee cuts to fund incentives.

QPP Participation

- Make the QPP voluntary for all physicians and groups.
- Eliminate payment penalties and budget neutrality that results in winners and losers; establish systems that encourage all physicians – and their patients – to be "winners."
- Notify eligible physicians of their participation status before the start of each QPP performance year.
- Develop a coordinated and meaningful initiative to educate all physicians through one platform rather than hold QPP webinars and post fact sheets and guides haphazardly on

several websites and at various times throughout the year. All education should be accredited for formal continuing medical education credits.
- Centralize all QPP information, education materials, and resources on one website rather than separate websites with multiple links on each web page.
- For physicians not in an APM or advanced APM, do not require they join voluntary groups.
- Voluntary groups, such as virtual groups, should remain optional with no associated payment penalty for nonparticipation.
- Reinstate the “pick your pace” options for physicians who voluntarily participate in the QPP.
- Create stability in QPP requirements. Do not change measures, data completeness criteria, data collection, and reporting requirements for at least two years so physicians can ease into the program. In addition, to reduce confusion and frustration, limit the number of acronyms used and re-phrased or new terminology introduced each year.
- Physicians who have no possibility of earning more than it costs them to report data and who are not in a position to accept risk should be exempt from the QPP.
- If QPP participation continues to be required rather than made voluntary, increase or at least maintain the low-volume threshold of $90,000 or 200 Medicare beneficiaries.

Electronic Health Records and Technology Vendors
- Eliminate arbitrary EHR requirements and allow physicians to determine how best to use their EHR.
- Redesign and overhaul certified EHR technology and enhance interoperability.
- Require EHR vendors to build and maintain products that meet all QPP specifications rather than force physicians to purchase and constantly upgrade expensive and often-balky systems.
- Redesign EHR technology and make data analytics platforms standard to support patient population management across all EHR and registry vendors.
- If technology requirements continue for physicians, shift the burden of meeting regulatory requirements from physicians to the for-profit EHR and registry vendor communities.
- Expand the extreme and uncontrollable circumstances policy to include issues with EHR, technology, registry, survey, and billing vendors who make data collection and submission errors that are out of physician control.
- When vendors make errors that affect physician participation and/or performance scores in the QPP, hold physicians harmless from any payment penalties and offer them the option to withdraw their performance scores from publication on Physician Compare.
- Create an annual Physician Compare-like report or website for EHR, technology, registry, and survey vendors associated with the QPP. Publish their data collection and submission error rates to help physicians make an informed decision about the right vendor for their practices.

QPP Quality and Cost Performance Metrics
- Use QPP quality and cost metrics that capture only those activities that are under the physician’s control and have been shown to improve quality of care, enhance access to care, and/or reduce the cost of care.
- Use only relevant and accurate QPP measures with clinically appropriate exceptions and exclusions.

- Apply proper risk adjustment to both QPP cost and quality measures to eliminate the impact of social determinants of health and other cultural or socioeconomic variables: poverty; poor educational attainment; cultural, racial, ethnic, and religious affiliation; and a history of uninsured status.
- Do not require QPP data unless it can be submitted automatically through EHR and/or registry vendors at no cost and with no manual entry required.
- Further simplify QPP data requirements to only the measures physicians find meaningful rather than what CMS terms "applicable measures."
- Keep patient experience surveys optional in the QPP.
- Continue the long-term project that CMS has started to identify episode-based measures. These measures, after development and testing with relevant physician specialties, may provide for better cost and quality attribution. Replace existing measures with the episode-based measures as they become available.
- Eliminate the requirement for all-payer data for the purposes of assessing physician performance and determining Medicare payment adjustments in the QPP.
- Add more improvement activities and do not change current activity requirements.

QPP APMs and Advanced APMs

- Participation in APMs or advanced APMs should always be voluntary for physicians.
- Preserve physician choice of payment model and do not force or coerce physicians into accepting a payment model that is unacceptably risky.
- Remove the requirement that physicians must accept insurance-type, downside risk to earn incentives in advanced APMs.
- Exempt from MIPS physicians who participate in advanced APMs but do not meet the required thresholds and grant them the 5-percent incentive payment for taking part in an advanced APM.
- Eliminate the Medicare annual charge amount and patient count thresholds required to achieve incentive payments in advanced APMs.
- Allow physician contracts with Medicare Advantage plans to count as advanced APMs.
- Create advanced APMs that include a low barrier to entry, and slow and gradual ramp-up to risk.
- Provide more education and technical assistance to physicians interested in developing their own physician-focused payment model proposal.
- Provide more education about how to make comments and recommendations on proposals under review by the Physician-Focused Payment Model Technical Advisory Committee.

QPP Performance Feedback, Targeted Review, Audits, and Physician Compare

- Make QPP performance feedback available within the current QPP performance year rather than during the data submission period.
- Make QPP scores and performance feedback data easy to access and understand.
- Extend the targeted review period from 30 days to 90 days and expand the process beyond a one-level review to provide physicians with a sufficient opportunity for a fair reconsideration to dispute performance scores and payment adjustment determinations.
- To prevent adversely affecting physician reputations via data published on Physician Compare, include only the QPP data that is transparent and meaningful, along with

explanations as to what factors may affect the data (e.g. varied benchmarks by individual measure and reporting method, lack of adequate risk adjustment.)

- Extend the preview period for data set to be published on Physician Compare from 30 days to 90 days to provide physicians sufficient time to preview and contest their scores if necessary.
- To promote program fairness, establish a fair and transparent data validation and auditing process with clear documentation requirements and data validation criteria before the start of each performance year rather than posting new or updated information mid-year.
- Extend the response time for data validation and audit notices from 10 days to at least 30 days to provide physicians additional time to respond to initial CMS-requested information.
- Improve program integrity to safeguard the validity and accuracy of MIPS data to ensure value-based payments are based on actual performance and not gaming of the QPP by advanced and sophisticated data systems.

Appendix: Summary of MACRA Implementation

MACRA Implementation to Date

CMS uses the annual rulemaking process to develop and finalize policies and regulations to implement the provisions in MACRA. The table below shows a timeline of key events surrounding MACRA implementation to date. The events illustrate the many changes physicians must undertake to comply with QPP requirements. In addition, the timeline highlights annual changes in physician fee schedule updates, the uncertainties of the QPP and Medicare payment, and the overall federal bureaucracy used to transition physicians to a value-based payment system.

Table 1. MACRA Timeline

Apr. 14, 2015	Following years of advocacy by the American Medical Association, TMA and others in organized medicine to repeal the SGR formula, Congress passes and President Barack Obama signs MACRA.[38] Beginning in 2017, the law requires participating physicians to choose between two major payment tracks: MIPS and APMs. The law also gives physicians a 0.5-percent fee increase starting in June 2015 and promises similar updates for the next four years.
Jan. 1, 2016	MACRA's 0.5-percent fee increase is overridden by "target recapture" provisions of previous legislation, specifically the Protecting Access to Medicare Act of 2014, resulting in a 0.36-percent reduction in most physician fees for 2016.
May 9, 2016	CMS publishes the 2017 proposed rule (425 pages) to establish new policies and regulations with stakeholder input to implement the provisions in MACRA the following year.[39]
Nov. 4, 2016	CMS publishes the 2017 final rule (824 pages) and provides physicians with only two months to prepare their practice for program readiness.[40] CMS introduces the framework (QPP) it will use to administer MIPS and APMs, and offers a "pick your pace" approach to participation. Annually thereafter, CMS will use rulemaking to set new or change existing policies and regulations that govern each QPP performance year.
Dec. 16, 2016	The Office of Inspector General (OIG) under HHS publishes an early implementation review report on CMS's management of the QPP.[41] The OIG identifies the following two vulnerabilities that are critical for CMS to address in 2017: 1) providing sufficient guidance and technical assistance to ensure that clinicians are ready to participate in the QPP, and 2) developing IT systems to support data reporting, scoring, and payment adjustment.
Jan. 1, 2017	The first QPP performance year begins, with physicians' 2019 Medicare payments set to change from -4 percent to +4 percent based on their 2017 performance. According to the 2017 QPP final rule, CMS is to notify physicians if they are required to participate at the start of the year, but it does not follow through on this action. The promised fee schedule increase is

	reduced by half, mostly due to target recapture, resulting in a fee increase of only 0.24 percent for 2017.
May 9, 2017	Four months after the first performance year begins, CMS launches a MIPS lookup tool and mails letters to physicians to inform them if they are required to participate in 2017.
June 30, 2017	CMS publishes the 2018 proposed rule (491 pages) with updates for the second and future years of the QPP.[42]
Nov. 16, 2017	CMS publishes the 2018 final rule (662 pages).[43] CMS exempts more physicians from MIPS in 2018 than in 2017, introduces MIPS virtual groups, and will start to phase in the MIPS cost category. In addition, CMS issues a final interim rule automatically exempting physicians whose practices are located in disaster-designated counties as a result of widespread natural disasters and disruptions in health care delivery in 2017.
Dec. 17, 2017	The OIG under HHS publishes a follow-up review report on CMS's management of the QPP.[44] The OIG identifies the following two vulnerabilities that are critical for CMS to address in 2018: 1) if clinicians do not receive sufficient technical assistance, they may struggle to succeed under the QPP or choose not to participate, and 2) if CMS does not develop and implement a comprehensive program integrity plan for the QPP, the program will be at greater risk of fraud and improper payments.
Jan. 1, 2018	The data submission window opens for the 2017 QPP performance year with a March 31 deadline. The second QPP performance year begins, with physicians' 2020 Medicare payments set to change from -5 percent to +5 percent based on their 2018 performance. CMS does not update the MIPS lookup tool or mail letters, and due to new exemption criteria, physicians do not know whether they are required to participate in the 2018 QPP performance year. Target recapture again partially offsets scheduled fee increases, resulting in only a 0.31-percent increase for 2018. Cumulatively, by now, physicians' Medicare fees should have increased by 2 percent since the passage of MACRA; instead, they have increased by just 0.69 percent.
Jan. 11, 2018	MedPAC votes 14-2 to recommend that Congress eliminate MIPS and replace it with a new program referred to as a voluntary value program (VVP).
Feb. 9, 2018	Congress passes and President Donald J. Trump signs the Bipartisan Budget Act of 2018, which includes technical amendments to MACRA.[45] Key changes include eliminating Medicare Part B drugs from MIPS payment adjustments, and giving CMS the flexibility to adjust the program's performance scoring threshold in years three through five of the QPP, allowing for physicians to make a more gradual transition to meeting their MIPS targets. The bill also cuts the promised 0.5-percent Medicare fee schedule update for 2019 in half.
Feb. 19, 2018	HHS releases its President's FY 2019 Budget Request.[46] Among the many proposals are recommendations to simplify government-imposed physician burdens in Medicare, including simplifying and eliminating reporting burdens associated with MIPS. The budget also recommends removing thresholds physicians must meet to receive a bonus in advanced APMs. In

	addition, HHS also recommends eliminating reporting burdens and arbitrary requirements related to EHRs.
Mar. 15, 2018	MedPAC releases its formal, annual report on Medicare payment policy to Congress in which it concludes that MIPS "will not fulfill its goals and therefore should be eliminated."[47] MedPAC recommends establishing a new voluntary value program in which physicians can self-organize into voluntary groups and qualify for value payments based on a uniform set of population-based measures. Under the new program, there would be no reporting required by physicians; CMS would calculate performance using data from administrative claims and patient experience surveys.
Mar. 21, 2018	CMS testifies on the implementation of MACRA's physician payment policies before the U.S. House Committee on Ways and Means, Subcommittee on Health.[48] CMS informs the subcommittee that the President's FY 2019 Budget Request includes a proposal to further simplify and reduce the reporting burden in MIPS but does not address the likelihood of its adoption.
Apr. 3, 2018	After a three-day extension by CMS, the data submission window for the 2017 QPP performance year closes on Apr. 3.
Apr. 13, 2018	About three and half months into the second QPP performance year, CMS announces that the MIPS lookup tool has been updated. Physicians can now check online via the QPP website to see if they are exempt or required to participate in 2018, but CMS would send no letters to physicians.
Mid-year 2018	CMS is expected to publish the proposed rule with updates for 2019 and future years of the QPP.
July 1, 2018	CMS is expected to provide physicians with 2017 QPP final scores, performance feedback, and payment adjustment determinations for 2019. The release of performance feedback will trigger a 60-day window for physicians to appeal 2017 performance scores and/or 2019 payment adjustment determinations.
November 2018	CMS is expected to publish the 2019 final rule.
December 2018	CMS is expected to publish physicians' 2017 QPP performance scores on Physician Compare on the medicare.gov website, making scores available to Medicare beneficiaries and the public.[49]
Jan. 1, 2019	Medicare payment adjustments and incentive payments begin based on 2017 performance. The third QPP performance year begins, with physicians' 2021 Medicare payments set to change from -7 percent to +7 percent based on their 2019 performance.

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