AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

MACRA ready
The Shift to Value-Based Payment

AAFP Advocacy of MACRA Final Rule

The final rule for MACRA implementation was released October 14, 2016. The AAFP has been advocating on key provisions to reduce administrative burden and bring about other changes in the rule to make family physicians' jobs easier. The final rule includes numerous policies that are the direct result of AAFP advocacy. This summary highlights final rule provisions and scores whether the AAFP is satisfied with the final rule provision or not.

Medal = AAFP advocacy was successful in implementing a change for this final rule provision.

Meter on Green = AAFP advocacy was satisfied about this final rule provision.
Meter on Red = AAFP advocacy was NOT satisfied about this final rule provision.
Meter in middle = AAFP advocacy was neutral about this final rule provision.

TOPIC	PROPOSED RULE	AAFP ADVOCACY MESSAGE	FINAL RULE
Solo and Small Practices	For reporting period 2017, physicians and groups (who are not otherwise excluded) are required to successfully meet the reporting requirements of the Merit-based Incentive Payment System (MIPS) to avoid a negative payment adjustment in 2019.	Practices with five or fewer physicians billing under the same tax identification number (TIN) who participate in MIPS by submitting quality data, using certified electronic health record technology (CEHRT), and participating in clinical practice improvement activities should be exempt from any negative payment adjustment until virtual groups are implemented. These practices should retain their eligibility for positive payment adjustments with overall program simplification by reducing the reporting requirements and administrative burden.	Pick Your Pace – 2017 will be a transition year. Physicians choose their level of participation in MIPS from one of four options: • Report one quality measure, one improvement activity, or all four of the required measures within the advancing care information (ACI) category and avoid the negative payment adjustment. • Report a minimum of 90 days for more than one quality measure, more than one improvement activity, or more than four of the measures within the ACI category to avoid the negative payment adjustment. Physicians will also be eligible for a small positive payment adjustment. • Report to MIPS for a full 90-day period or full year to avoid the negative payment adjustment. Physicians will also maximize their chances for a moderate positive payment adjustment in 2019. • Participate in an Advanced Alternative Payment Model (AAPM) The AAFP will continue to advocate for further relief for solo and small group practices.
Low-volume Threshold	Physicians who have Medicare billing charges of $10,000 or less and provide care to fewer than 100 Medicare beneficiaries	Physicians who have Medicare billing charges of $10,000 or less or provide care to fewer than 125 Medicare beneficiaries	Physicians and groups who have Medicare billing charges of $30,000 or less or provide care to fewer than 100 Medicare beneficiaries
Performance Period	Full calendar year beginning January 1, 2017	Performance period should start no earlier than July 1, 2017. Ideally, the performance period should not begin before 2018.	Under Pick Your Pace, physicians have the option to report a minimum of 90 days or a full calendar year for a potential positive payment adjustment. The last day to start reporting is October 2, 2017.

Topic	Proposed Rule	AAFP Advocacy Message	Final Rule
Virtual Groups	Virtual groups will not be implemented until the 2018 performance period.	Create an interim pathway to virtual groups. Practices with five or fewer physicians billing under the same TIN who participate in MIPS by submitting quality data, using CEHRT, and participate in clinical practice improvement activities should be exempt from any negative payment adjustment until virtual groups are implemented. These practices should retain their eligibility for positive payment adjustments.	 Virtual groups will not be implemented until 2018. The Centers for Medicare & Medicaid Services (CMS) created the Pick Your Pace pathway to assist practices in transition. Securing the virtual group option will be an advocacy priority for the AAFP in 2017.
Quality Measurement 	Physicians must report six quality measures, including one cross-cutting measure and one outcome measure. CMS will also calculate total all-cause hospital readmissions and two ambulatory care sensitive conditions (ACSC) composite measures using administrative claims data.	Align measures within the Family Medicine/General Practice Specialty Measure Set with the Primary Care Core Measure Set. All specialists and sub-specialists should be held to the same reporting requirements as all MIPS participants. Total all-cause hospital readmissions and ACSC composite measures should be tested in the program before being included in the composite score.	 Physicians must report at least six measures, one of which must be an outcome measure. Physicians are no longer required to report a cross-cutting measure. The only measure that CMS will calculate that physicians will not report is the total all-cause hospital readmissions. This will be calculated for the first performance period. Quality will account for 60% of the physician's final score for the first performance year.
Core Measures 	The core measures, while included in the long listing, did not appear within the Family Medicine/General Practice MIPS Specialty Measure Set.	Align the proposed quality measures with the Core Measure Set and clearly indicate the Core Measures within Family Medicine/General Practice Specialty Measure Set.	 The core measures are included in the measures available for MIPS reporting. The AAFP will continue to advocate for measure alignment and simplification.
Cost (Resource Use) 	CMS will calculate cost measures using administrative claims data. Physicians will be evaluated on Medicare spending per beneficiary (MSPB), total per capita costs, and episode-based measures.	Remove both total cost of care and MSPB from the Cost performance category and use care episode groups to evaluate physicians on resource use.	 Cost category will not be included in the final score for the 2017 performance year and will be weighted at 0%. CMS will still provide feedback information to physicians on MSPB and total cost of care.
Advancing Care Information (ACI) (formerly Meaningful Use of CEHRT)	Physicians must report a numerator and denominator for a set of objectives and measures to receive 50% of the category score. A physician could earn additional points above the base score for their performance in objectives and measures for patient electronic access, coordination of care through patient engagement, and health information exchange.	New construct for the ACI component of MIPS, recommending that requirements and scoring be simplified. A base score should be based on the use of CEHRT and protecting health information **only**. Performance category scoring should be based on the number of functionality (currently represented by the proposed measures) available and utilized in the reporting period, **not** based on thresholds. The establishment of a post-market surveillance system to allow physician reporting of events where CEHRT is not living up to certification requirements.	 In 2017, physicians must report a numerator and denominator for four required measures to earn half of the ACI category score. Physicians can report on additional measures to earn a higher score. ACI will be weighted at 25% for the first performance period. Expanded oversight of CEHRT, including in-the-field surveillance. The AAFP will continue to advocate for CMS to increase simplification and move beyond health IT utilization measures.

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Improvement Activities	Physicians must submit a total of six medium-weighted or three high-weighted activities. Physicians in small practices, rural areas, or who are located in a health professional shortage area (HPSA) must submit a minimum of two improvement activities (either medium or high-weight).	CMS should recognize performance improvement continuing medical education activities provided by national accreditors.	 Physicians must submit a total of four medium-weighted or two high-weighted activities. Physicians in small practices, rural areas, or who are located in HPSAs must submit one high-weight activity or two medium-weight activities. CMS will consider including additional activities provided by national accreditors in future rulemaking. Improvement activities will be weighted at 15% for the first performance period.
Medical Home for MIPS, Patient-Centered Medical Home (PCMH) 	Certified medical homes receive the highest potential score in the clinical practice improvement activities performance category. A PCMH must be accredited by the Accreditation Association of Ambulatory Health Care (AAAHC), the National Committee for Quality Assurance (NCQA), the Joint Commission, or the Utilization Review Accreditation Commission (URAC).	Physicians should not be required to pay a third-party accrediting body to receive recognition as a medical home. Expand recognized certification organizations to include state-based, payer-sponsored, and regional PCMH recognition programs.	 Recognized certification organizations expanded to include state-based, regional or state-based programs, private payers, or other entities that administer PCMH accreditation to at least 500 practices. If one practice under the TIN has PCMH recognition, then the entire TIN will qualify for full points within the improvement activities category.
Nominal Financial Risk 	To qualify as an AAPM, the model must meet requirements for marginal, total, and minimum loss rate. The marginal risk must be at least 30%, the total risk must be at least 4%, and the minimum loss rate can be no greater than 4%.	Simplify the risk criteria by removing the marginal risk requirement. The total risk should be based on the entity's Medicare Part A and B revenue rather than its benchmark.	 Nominal risk criteria reduced to include only total potential risk. AAPMs can satisfy this requirement if the total risk under the AAPM is at least 8% of the participating entity's Medicare Part A and B revenue, or if the total risk under the AAPM is at least 3% of the benchmark for which an entity is responsible.
Financial Risk for Medical Homes within AAPM	To qualify as a Medical Home Model AAPM, the AAPM must require entities be at risk for: • 2.5% of Medicare Parts A and B revenue in 2017 • 3% of Medicare Parts A and B revenue in 2018 • 4% of Medicare Parts A and B revenue in 2019 • 5% of Medicare Parts A and B revenue in 2020 and beyond	Medical Home Models should not be held responsible for any financial risk.	 Medical Home Model AAPMs must require entities to be at risk for: • 2.5% of Medicare Parts A and B revenue in 2017 • 3% of Medicare Parts A and B revenue in 2018 • 4% of Medicare Parts A and B revenue in 2019 • 5% of Medicare Parts A and B revenue in 2020 and beyond This will be an advocacy priority for the AAFP in 2017.

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Medical Home Model for Alternative Payment Model	Medical Home Models must have a primary care focus and empanel patients to a primary clinician. Medical Home Models must also have at least four of the following elements: • planned coordination of chronic care and preventive care, • patient access and continuity of care, • risk-stratified care management, • coordination of care across the medical neighborhood, • patient and caregiver engagement, • shared decision-making, and • payment arrangements, in addition to, or substituting for fee-for-service payments (for example, shared savings, population-based payments).	Congress fully supported the medical home and intended for the medical home to be recognized as an AAPM.	 Medical Home Models must have a primary care focus and empanel patients to a primary clinician. Medical Home Models must also have at least four of the following elements: • planned coordination of chronic care and preventive care, • patient access and continuity of care, • risk-stratified care management, • coordination of care across the medical neighborhood, • patient and caregiver engagement, • shared decision-making, and • payment arrangements, in addition to, or substituting for fee-for-service payments (for example, shared savings, population-based payments).
Limited Advanced APMs	Approved AAPMs include: CPC+, Next Generation Accountable Care Organization (ACO), Medicare Shared Savings Program Tracks 2 and 3, comprehensive end-stage renal disease (ESRD) through a non-large dialysis organization arrangement, Oncology Care Model (two-sided risk model).	Broaden the definition of an Expanded Medical Home Model and conduct a rapid review of the original Comprehensive Primary Care (CPC) initiative program and expand as quickly as possible. CMS should engage closely with the Physician-Focused Payment Model Technical Advisory Committee to ensure there are more primary care AAPMs available.	 CMS will explore the option of creating a "Medicare ACO Track 1+ Model," which would incorporate limited downside risk, but still qualify as an AAPM. The AAFP will continue to advocate for the increased availability of primary care AAPMs.
CPC Plus	CPC+ was the only APM that met Medical Home Model criteria to be an AAPM.	CPC+ is an important model available as an AAPM but has a limited availability for family physicians to participate due to a single enrollment period and limited regions selected.	 CMS will closely monitor the results of CPC+ in order to determine whether it meets the statutory criteria for expansion in the future.
Medical Home as Expanded Under Section 1115A(c)	No Medical Homes have been expanded under section 1115A(c) CMS will post their official determination of AAPMs prior to the start of the first Qualifying APM Participants Performance Period.	CMS was urged to institute a rapid review of the original CPC initiative and expand the program as quickly as possible.	 Expansion of the CPC initiative is outside the scope of the final rule. CMS will continue to consider whether CPC meets the statutory expansion criteria.