AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

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AAFP Advocacy of the Quality Payment Program (QPP) Final Rule

The final rule for Quality Payment Program (QPP) implementation was released November 2, 2017. The AAFP advocated on key provisions of the QPP 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	FINAL RULE
Small Practice Bonus 	Eligible clinicians (ECs) in small practices (15 or fewer) will receive a five-point bonus added to their final score for the 2018 performance period if they submit data for at least one performance category.	The AAFP strongly supports the small practice bonus and urges the Centers for Medicare & Medicaid (CMS) to continue it beyond the 2018 performance period.	 The rule is finalized as proposed. CMS will revisit this bonus in future program years.
Complex Patient Bonus 	• ECs will receive a complex patient bonus (up to three points) based on either their average hierarchal condition category (HCC) risk score or proportion of dual-eligible patients. • A bonus would only be available for the 2018 performance period.	The AAFP supports: • Using average HCC risk scores to determine an EC's complex patient bonus. • Extending the complex bonus beyond the 2018 performance period.	 • ECs will receive a complex patient bonus (up to five points) based on their average HCC risk score **AND** proportion of dual-eligible patients. • A bonus is available to ECs who submit data for at least one performance category.
Medical home for the Merit-based Incentive Payment System (MIPS), Patient-centered Medical Home (PCMH) 	At least 50% of practice sites within a tax identification number (TIN) must be recognized PCMHs for the entire TIN to receive full credit in the improvement activities performance category.	The AAFP supports this proposal.	 The rule is finalized as proposed.
Advancing Care Information (ACI) 	• ECs must report at least 90 days of data. • ECs can continue to use 2014 edition certified electronic health record technology (CEHRT), 2015 edition CEHRT, or a combination of both. • ECs who report using only 2015 edition CEHRT will receive a 10-percentage point bonus to their ACI score. • ECs can attest to a public health or clinical data registry, in lieu of the immunization registry in the performance category. Each public health or clinical data registry would be worth five points, with a maximum of 10 points available. • A hardship exemption was added for ECs whose CEHRT was decertified during the performance period and for small practices.	The AAFP supports: • Allowing ECs to continue using 2014 edition CEHRT. • Allowing ECs who report using a combination of 2014 and 2015 edition CEHRT to receive a five-point bonus. • ECs that attest to a public health or clinical data registry, in lieu of the immunization registry, should receive 10 points. • ECs whose CEHRT was decertified during the performance period should receive an automatic exemption from the ACI category	 • ECs must report at least 90 days of data. • ECs can continue to use 2014 edition CEHRT, 2015 edition CEHRT, or a combination of both. • ECs who report using only 2015 edition CEHRT will receive a 10-percentage point bonus to their ACI score. • ECs can attest to a public health or clinical data registry, in lieu of the immunization registry in the performance category, and receive **10 points**. • A hardship exemption was added for ECs whose CEHRT was decertified during the performance period and for small practices.

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Hardship Exemption for Quality, Cost, and Improvement Activities Performance Categories	ECs can apply for a hardship exemption for the quality, cost, and improvement activity categories. This is a separate application from the ACI hardship exemption application.	The AAFP supports this proposal.	The rule is finalized as proposed.
Virtual Groups	• Solo clinicians and small practices (10 or fewer reporting under a National Provider Identifier [NPI]) can combine to form a virtual group (VG). • All ECs and groups must be above the low-volume threshold to receive payment adjustments as part of a VG. • VG election must be made by December 1, 2017, for the 2018 performance period.	The AAFP supports that solo clinicians and groups who are excluded from MIPS because of the low-volume threshold should be able to opt-in and participate in a VG.	• Solo clinicians and small practices (10 or fewer reporting under a NPI) can combine to form a VG. • All ECs and groups must be above the low-volume threshold to receive payment adjustments as part of a VG. • VG election must be made by **December 31, 2017**, for the 2018 performance period.
Low-volume Threshold	ECs and groups who have Medicare Part B billing charges of $90,000 or less, or provide care to fewer than 200 Medicare Part B beneficiaries, qualify for the low-volume threshold.	The AAFP supports providing a pathway to opt-in for ECs and groups of any size who are excluded due to the low-volume threshold.	The rule is finalized as proposed.
Performance Period	The performance period is: • A full calendar year (January 1-December 31, 2018) for the quality and cost performance categories. • 90 days for the improvement activities and ACI performance categories.	The AAFP supports the performance period be 90 days for each performance category.	The rule is finalized as proposed.
Data Completeness	ECs must submit data for at least 50% of patients that qualify for a measure, regardless of payer (except for claims and Web Interface reporters).	The AAFP supports the continuation of the 50% data completeness criteria.	ECs must submit data for at least **60%** of patients that qualify for a measure, regardless of payer (except for claims and Web Interface reporters).
Cost Measurement	• The cost performance category increases to 10%, or continues to reweight cost to 0% for the 2018 performance period. • ECs will be measured on total per capita costs and Medicare Spending per Beneficiary (MSPB). • CMS will work to develop new episode-based measures for future program years.	The AAFP supports: • A gradual ramp-up to the statutorily required 30%. • Not measuring ECs in small practices on cost until more reliable measures are developed. All other ECs and groups should only be measured on cost, only if CMS can reliably score at least one episode-based measure. • Thoroughly testing all new episode-based measures before they are used in the program.	• Cost will be weighted at **10%** for the 2018 performance period, and increase to 30% for the 2019 performance period. • ECs will be assessed on total per capita costs and MSPB, and CMS will work to develop new episode-based measures. • Episode-based measures will not be used in 2018.