AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Executive Summary of the MACRA Final Rule

On October 14, 2016, the Centers for Medicare & Medicaid Services (CMS) released a final rule that implements the Medicare Quality Payment Program (QPP) called for in the bipartisan *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA).

The MACRA final regulation includes several policies that are the direct result of AAFP advocacy. In particular, the "Pick Your Pace" policy includes the option of a 90-day reporting period in 2017. In comparison, the proposed rule called for a full calendar year reporting period. Additionally, if a practice participates in the MIPS program (no matter how long), there will be no penalty in 2019. Another success AAFP advocated for is the granting of all physicians participating in the Medicare program to receive a 0.5% update in payments for services provided in 2017.

The QPP has two tracks from which you can choose:

- The Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (APMs)
    - If you decide to participate in an Advanced APM through Medicare Part B, you may earn an incentive payment for participating in an innovative payment model.

Merit-based Incentive Payment System (MIPS)

Physicians who participate in Medicare, provide Medicare Part B services, and are not part of a recognized Advanced APM, will participate in the MIPS program starting in 2017. CMS designated 2017 as a "transition year." It will be the performance period for the 2019 MIPS payment year.

The MIPS program combines existing quality and performance improvement programs—PQRS, Value-based Modifier, and Meaningful Use—and rolls them into a single performance program. The single program contains four performance categories: quality, advancing care information, improvement activities, and cost. A physicians' performance in these four categories will determine their performance score and their payment rate.

The MIPS performance threshold in 2017 will be three out of a possible 100 points. This means that eligible physicians will only need to score three points to avoid a negative payment adjustment in 2019. **CMS estimates that more than 90% of MIPS-eligible clinicians will receive a positive or neutral payment adjustment in the transition year.** Eligible clinicians who achieve a final performance score of 70 or higher will be eligible for a portion of the "exceptional performance adjustment," funded from a pool of $500 million.

Quality, 60% of 2017 performance score

- Physicians are required to report on six quality measures, one of which must be an outcome measure. CMS originally proposed nine quality measures.
- Quality measures will be selected annually and published by November 1 each year.

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Advancing Care Information, 25% of 2017 performance score

- Advancing Care Information (ACI) transitions from the Meaningful Use program, with a focus on health information technology implementation.
- Under ACI, eligible physicians need to report on only four required measures in 2017 for full participation in the ACI performance category, and can report for at least 90 days. CMS had proposed up to 18 measures and full-year reporting.

Improvement Activities, 15% of 2017 performance score

- MIPS-eligible physicians in a practice certified as a patient-centered medical home (PCMH) will receive the highest potential score for this category.
- CMS expanded the definition of acceptable PCMH certification or accreditation to include: a national program; a regional or state program; a private payer; or other body that certifies at least 500 or more practices. See page three and the medical home comparison at the end of this document for additional details.
- CMS reduced the number of activities required in 2017 to achieve full credit from six medium-weighted or three high-weighted activities to four medium-weighted or two high-weighted activities.
- For small practices, rural practices, or practices located in geographic health professional shortage areas (HPSAs), MIPS-eligible physicians are only required to report one high-weighted or two medium-weighted activities for full participation.
- CMS did not finalize AAFP's suggestion to recognize performance improvement continuing medical education (PI-CME) activities that are provided by nationally-recognized accreditors as official improvement activities. CMS will consider these recommendations for additional activities in future years.

Cost, 2017, 0% of 2017 performance score

- This category will be calculated from adjudicated claims by CMS, and no data submission by clinicians is required.
- In performance period 2017, this category has been reweighted to 0%. The percentage for this category will increase to 10% for performance period year two.

<u>**Practices can "Pick Your Pace" from four options:**</u>

- **Test** – If you submit a minimum amount of 2017 data to Medicare, you can avoid a downward payment adjustment in 2019. A minimum amount of data can be as minimal as one quality measure, one improvement activity, or only four 2017 advancing care information measures.
- **Partial Participation** – If you submit more than one quality measure, more than one improvement activity, or more than the required measures in advancing care information for a period of 90 days in 2017, you may earn a neutral or small, positive payment adjustment in 2019.
- **Full Participation** – If you submit for a full 90-day period or a full year of 2017 data in all categories to Medicare, you may earn moderate positive payment updates in 2019.
- **Advanced APM** – If you receive 25% of Medicare Part B payments or see 20% of your Medicare patients through an Advanced Alternative Payment Model in 2017, then you earn a 5% incentive payment in 2019.

Important Note: Failure to report even one measure or activity in 2017 will result in a negative 4% adjustment in Medicare payments in 2019.

Exemptions – If your Medicare allowable charges are less than $30,000 a year <u>or</u> you do not provide care to more than 100 Medicare fee-for-service (FFS) patients in a year, you are exempt from participation in the Quality Payment Program. However, if your Medicare allowable charges <u>exceed</u> $30,000 a year, <u>or</u> you provide care to <u>more than</u> 100 Medicare FFS patients a year, then you are subject to MIPS. Additionally, if

2017 is your first year as a Medicare participating physician, then you are exempt from participation in the MIPS program. Alternatively, you may participate in an Advanced APM.

CMS estimates that more than half of physicians (between 738,000 to 780,000 clinicians, representing 22 to 27% of total Part B allowed charges) will be excluded from MIPS due to:

- Not being one of the MIPS-eligible physicians for 2017 (200,000 clinicians, or 14.4%).
- Falling below the low-volume threshold.
- Being a qualifying APM participant (between 70,000 to 120,000 clinicians or 5 to 8%).

Advanced APMs

Physicians who provide care to Medicare patients through a recognized Advanced APM will be eligible for a 5% bonus payment. CMS estimates that 30,000 to 90,000 clinicians could be qualifying APM participants in 2017, and that approximately 25% of eligible Medicare clinicians could be in an Advanced APM by the second year of the program.

To be an Advanced APM, an APM must require participants to use certified electronic health record (EHR) technology; provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the MIPS; and either: (1) be a Medical Home Model expanded under CMS Innovation Center authority, or (2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses.

- Two types of Advanced APMs were finalized: Advanced APMs and other payer Advanced APMs.
- CMS is reviewing other models established through the CMS Innovation Center and is in the process of updating and possibly re-opening these models. The agency will post an initial set of Advanced APM determinations no later than January 1, 2017.
- Medical Home Models:
    - New standards by which Medical Home Models may meet the financial risk criteria to be an Advanced APM were also established. These standards are detailed in a medical home comparison on the final page of this summary.
    - A Medical Home Model as an APM entity is required to have the following elements:
        - A primary care focus consisting of primary care or multispecialty practices with primary care physicians and practitioners that offer primary care services. For the purposes of this provision, primary care focus includes eligible clinicians practicing under one or more of the following designations: general practice; family medicine; internal medicine; obstetrics and gynecology; pediatric medicine; geriatric medicine; nurse practitioner; clinical nurse specialist; and physician assistant.
        - Empanelment of each patient to a primary clinician.
    - In addition to these required elements, a Medical Home Model must have at least <u>four</u> of the following additional elements:
        - Planned coordination of chronic 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
        - Payment arrangements, in addition to, or substituting for fee-for-service payments (for example, shared savings, population-based payments)
- The final rule simplifies the financial risk criteria (standards) for Advanced APMs.

- CMS will explore a new Advanced APM in 2018, called "ACO Track 1+," which will require lower levels of risk than other accountable care organizations (ACO).

MIPS APMs

- In 2017, some APMs will not meet requirements to be categorized as Advanced APMs. Physicians in these APMs (referred to as MIPS APMs), will be subject to MIPS reporting requirements and the MIPS payment adjustment.
- MIPS-eligible physicians who participate in MIPS APMs will be scored using a different scoring standard than used in MIPS.

Small and Rural Practices

- **CMS estimates that at least 80% of clinicians in small and solo practices with one to nine clinicians will receive a positive or neutral MIPS payment adjustment in 2019.**
- CMS raised the low-volume threshold to be less than or equal to $30,000 in Medicare Part B allowed charges, or less than or equal to 100 Medicare patients. This will exclude more small practices from being subject to penalties under MIPS. CMS proposed a threshold of $10,000 in annual Medicare revenue, and less than 100 Medicare patients.
- CMS will offer technical support to small and rural practices.
- CMS is not implementing virtual groups in 2017, but is intending to do so in future years.

Performance Feedback

- Performance feedback will go to MIPS-eligible physicians initially on an annual basis, but in future years on a more frequent basis.
- Feedback will be provided using a web-based application.
- Health information technology (IT) vendors and registries will help disseminate data contained in the performance feedback to MIPS-eligible physicians.
- MIPS performance information will be publicly reported through the Physician Compare website.

CAHs, RHCs, FQHCs and MIPS

- CMS clarified that Medicare Part B professional services furnished at Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) can be counted towards the MIPS low-volume threshold.
- CMS clarified that the RHC all-inclusive rate and the FQHC prospective payment system are exempt from MIPS.

AAFP Resources

- AAFP MACRA Ready resources (aafp.org/macraready)
- AAFP press statement (aafp.org)
- *AAFP News* article on the final rule (aafp.org)

CMS Resources

- Medicare Quality Payment Program website
- Executive summary of the final rule
- CMS press release, blog, and fact sheet about the regulation
- CMS Assistance - qpp@cms.hhs.gov or 1.866.288.8292

MACRA Medical Homes Defined

Two distinct definitions are used for “medical home” in the Medicare Access and CHIP Reauthorization Act (MACRA). One definition is associated with each payment pathway. Use this information to help you understand the definitions and advantages of each “medical home” for the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (AAPM) pathways.

Merit-Based Incentive Payment System Certified Medical Home

The Centers for Medicare & Medicaid Services (CMS) expanded certification to include a MIPS-eligible clinician or group that has received certification or accreditation as a patient-centered medical home (PCMH) or comparable specialty practice from any of these entities:

- National program;
- Regional or state program;
- Private payer; or
- Other body that administers PCMH accreditation or comparable specialty practice certification.

Certifying or accrediting entities other than a national program must have 500 or more certified practices.

Advantages of being a Certified Medical Home:

- Receive full credit for the improvement activities performance category (15 percent of the final score for the 2017 performance period).
- If at least one practice in a larger group is “certified,” then the entire group reporting under that tax identification number (TIN) receives full credit in the improvement activities category.

Advanced Alternative Payment Model Medical Home Model

As of November 1, 2016, the only “Medical Home Model” identified by CMS that meets the qualifications below is the Comprehensive Primary Care Plus (CPC+) program.

A Medical Home Model needs to meet the following qualifications:

1. Have a primary care focus;
2. Offer primary care services with patients empaneled to a primary clinician; and
3. Have at least four of the following additional elements:
    - Planned coordination of chronic 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
    - Payment arrangements, in addition to, or substituting for, fee-for-service payments (e.g., shared savings, population-based payments).

Each AAPM will have its own financial risk standard. However, the final rule indicates a minimum amount of financial risk is required for Medical Home Model AAPMs and other AAPMs.

Advantages of participating in a Medical Home Model:

Financial Risk

Performance Period*	Medical Home Model	Other AAPMs
2017	2.5% Medicare Parts A & B revenue	8% estimated Medicare Parts A & B revenue OR ≥ 3% of expected expenditures
2018	3% Medicare Parts A & B revenue	8% estimated Medicare Parts A & B revenue OR ≥ 3% of expected expenditures

* For the 2017 performance period, there is no size restriction to qualify for the Medical Home Model financial risk standards. For the 2018 performance period, there will be a limit of 50 eligible clinicians in the entire parent organization to qualify for the lower financial risk.