

Overview of Advocacy Results on Major MACRA Rule Provisions

-  Use of this symbol in the chart below means that the AMA successfully advocated for a key change in the QPP final rule.
-  Use of this symbol in the chart below means that the AMA successfully advocated for a partial key change in the QPP final rule.

TOPIC	PROPOSED RULE	AMA RECOMMENDATION	FINAL RULE
KEY ISSUES			
Avoiding the QPP Penalty	Physicians must successfully report in all 4 MIPS categories in order to avoid the MIPS penalty	Allow a transition year with reduced reporting burdens for physicians. Ensure that all physicians have the opportunity to be successful under the QPP.	 The only physicians who will experience a penalty in 2019 are those who choose to report no data. Physicians who report for one patient on 1 quality measure, 1 improvement activity or the 4 required ACI base measures in 2017 will avoid a penalty.
Performance Period	Physicians must report for a full calendar year to be eligible for a positive payment adjustment.	Establish a transition period to allow for sufficient time to prepare physicians to have a successful launch of MACRA	 Physicians who report for at least 90 continuous days will be eligible for positive payment adjustments.
Low-Volume Threshold	Physicians with less than \$10,000 in Medicare allowed charges AND fewer than 100 Medicare patients per year.	Raise the reporting threshold to less than \$30,000 in Medicare revenue OR 100 or fewer Medicare patients per year.	 Physicians with less than \$30,000 in Medicare revenue or 100 or fewer Medicare patients per year.
Virtual Groups	Establish virtual groups in the 2018 performance period.	Finalize the concept of virtual groups.	CMS did not finalize the concept of virtual groups. CMS plans to allow physicians to form virtual groups beginning in 2018.

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MIPS PROGRAM QUALITY			
Reporting Burden	Physicians are required to report on 6 quality measures including one cross-cutting measure and one outcome or high priority measure.	Reduce the number of required quality measures from 6 to 4 and eliminate the cross-cutting measure requirement.	👍 Physicians are required to report 6 quality measures including one outcome or high priority measure. CMS eliminated the cross-cutting measure requirement.
Global and Population-Based Measures	Physicians will also be scored on 3 population-based measures: acute and chronic composite measures, and the all-cause hospital readmissions measure using administrative claims data.	Make global and population-based measures optional.	👍 CMS eliminated the acute and chronic composite measures. In addition, CMS increased the size of the groups required to participate in the all-cause hospital readmission measure from 10 to 15.
Data Thresholds	Data completeness requires physicians to report on 90 percent of all patients, regardless of payer, if using EHR, registry, or QCDR submission methods and report on 80 percent of all Medicare Part B patients if using claims submission method.	Require reporting on 50 percent of patients for all reporting methods.	👍 In 2017, physicians have to report a measure for 50 percent of patients, and in 2018, they must report on 60 percent of patients. If only avoiding a penalty and not attempting to earn an incentive, only required to report on 1 patient.

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COST			
Score Weighting	Cost performance category will make up 10 percent of a physician's composite performance score.	Recommend reducing the weight of the cost category to zero.	 The cost performance category is reduced to zero percent of the composite performance score in 2017.
Episode-Based Measures	Proposed 41 episode-based measures.	The 41 measures have yet to be finalized or fully vetted. Should slowly transition to episode-based measures and initially make them optional.	 CMS finalized 10 episode based measures in 2017. Physicians will receive information on how they did on these measures but since the weight of the cost category is zero in 2017, these measures will not count against physicians this year.
Administrative Claims Measures	CMS will use total cost per capita and Medicare Spending Per Beneficiary measures to evaluate physician's resource use.	Remove administrative claims measures that were developed primarily for other settings and include costs outside of the physician's control.	Retains the total cost per beneficiary and Medicare Spending Per Beneficiary administrative claims measures.

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IMPROVEMENT ACTIVITIES			
Reporting Burden	Physicians must report three 20-point high-weighted activities or six 10-point medium-weighted activities (or another combination of high and medium weighted activities equally 60 or more points) to achieve full credit in the improvement activity performance category.	Decrease the number of required improvement activities.	 Physicians must attest to two 20-point high-weighted activities, four 10-point medium-weighted activities, or another combination of high and medium-weighted activities equaling 40 points or more to achieve full credit in the improvement activity performance category.
Accommodations for Small, Rural, Health Professional Shortage Area (HPSA), and Non-Patient Facing Physicians	Small, rural, HPSAs, or non-patient facing physicians must report two CPIAs regardless of weight.	Allow entities who report on two medium-weighted or one high-weighted activity to achieve full credit in this category.	 Two medium-weighted activities or one high-weighted activity are required for small, rural, HPSA, or non-patient facing physicians.
APMs	APMs, regardless of the model or activities being performed by the APM, will receive half credit for the CPIA category.	Provide full CPIA credit to APMs	 APM Entities participating in the 2017 MIPS APMs receive full credit toward Improvement Activities in 2017.
High-Weighted Activities	Only eleven out of more than 90 CPIAs are identified as high-weighted.	Expand the number of high-weighted activities.	 The final rule increases the number of highly-weighted activities available to physicians.
Medical Homes Definition	A PCMH will be recognized if it is a nationally recognized accredited PCMH or	Expand the recognized certification entities for medical homes and similar specialty recognition programs to include including state-	 Participants that have received certification or accreditation as a PCMH or

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	comparable specialty practice.	based, payer sponsored, and regional medical home recognition programs.	comparable specialty practices, including those certified by a national program, regional or state program, private payer or other body that administers PCMH accreditation and certifies 500 or more practices for PCMH accreditation or comparable specialty practice certification will receive full credit in the CPIA performance category.
ADVANCING CARE INFORMATION (ACI)			
Reporting Burden	There are two parts to the ACI score, a Base Score and a Performance Score. Physicians are required to report on the Base Score of 11-16 measures to receive credit in the ACI performance category. The Performance Score consists of 8 measures with performance scoring based on 100 percent of patients.	Eliminate the pass-fail approach retained in the Base Score, reduce number of measures physicians are required to report, and award full credit in the Performance Score when a physician reports on 50 percent of patients.	👍 Physicians are required to report on a reduced number of ACI measures in the Base Score (4 in 2017, 5 thereafter), with an additional 9 optional measures in the Performance Score, for which physicians may receive additional percentage points.
Reporting Period	Physicians must report on the ACI category for a full calendar year.	Establish a 90-day reporting period for the ACI category.	👍 In 2017 and 2018, physicians must report the ACI category for a minimum of 90-days.
Coordination Between Performance Categories	CMS seeks comment on the concept of a holistic approach to	Leverage the proposed CPIAs and utilize existing but relevant ACI	👍 Physicians can earn bonus points in the ACI performance

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	health IT to directly link health IT adoption and use to patient outcomes, moving MIPS beyond the measurement of EHR adoption and process measurement and into a more patient-focused health IT program.	measures to facilitate reporting on these activities to create a more integrated program.	category by using CEHRT to complete certain activities in the Improvement Activities performance category.
ADVANCED ALTERNATIVE PAYMENT MODELS (APMs)			
Definition of “More Than Nominal Risk”	To qualify as a Medicare Advanced APM, the APM must meet the requirements for marginal risk, minimum loss rate, and total risk.	Simplify the definition of more than nominal financial risk.	👍 To qualify as a Medicare Advanced APM, the APM must only meet the requirement for total risk.
Amount of Risk that is “More than Nominal”	Physicians are required to pay up to 4 percent of total Medicare spending to qualify as an Advanced APM.	Reduce the amount of risk defined as more than nominal.	👍 An APM will qualify as an Advanced APM in 2019 and 2020 if the APM Entity is either (1) at risk of losing 8 percent of its own revenues when Medicare expenditures are higher than expected, or (2) at risk of repaying CMS up to 3 percent of total Medicare expenditures, whichever is lower.