AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Talking Points

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MACRA Proposed Regulations

The AAFP continues to support the core reforms set forth in MACRA.

- We believe this law, at its core, is designed to strengthen primary care and make primary care a strong foundation for payment and delivery reform for physician services under Medicare.

We support numerous provisions included in the regulation.

- Overall, we applaud CMS for identifying and adhering to the fundamental provisions of the law.
- In general, CMS accurately identified the key elements of the law:
  - Create a streamlined quality and performance program inside the fee-for-service system.
  - Create opportunities for physicians to participate in alternative payment models.
- We also believe that CMS has made some effort to simplify the program and to eliminate the pass/fail evaluation processes although, again, we think much work remains.

While our support for MACRA remains strong, we see a strong and definite need and opportunity for CMS to reconsider the approach to this proposed rule which we view as overly complex and burdensome to our members and indeed for all physicians. We also call on CMS to issue an interim final rule with comment period so the AAFP can continue to work with CMS to ensure that this law is successful.

We remain concerned that a January 1, 2017, start date does not provide adequate time for education and practice adjustments that will be required to ensure the successful implementation of the quality payment programs in a majority of family physician practices. We call on CMS to prolong the start of the performance period until at least July 1, 2017.

- If CMS issues the final rule for MACRA implementation on or around October 1, 2016, our members will need more than three months to develop a quality plan, ensure EHR functionality, identify and select relevant clinical practice improvement activities, and make necessary changes to reporting mechanisms.
- Furthermore, physicians will need to align their Medicare activities with similar activities in Medicare Advantage, Medicaid, and the commercial insurance markets.

All measures used in MIPS and APMs must be clinically relevant, harmonized and aligned among all public and private payers, and minimally burdensome to report.

- To accomplish this, the AAFP recommends that CMS use the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers.

The AAFP believes that the reporting burden under MIPS should be equivalent for all participating physicians.

- We believe that parity in reporting across all physician groups is critically important.
- To accomplish equivalency in the reporting burden, we believe that all physicians participating in the MIPS program should be required to meet the same program expectations as other MIPS participants and report on six measures.
    - If six measures are not available in the sub-specialty list, the MIPS-eligible clinicians need to report at the higher specialty level.
    - If six measures are still not available that are specialty specific, these MIPS-eligible clinicians should choose measures from the list of cross-cutting measures until they reach a total of six measures.
    - If CMS requires a lower number of quality measures for a particular specialty group in MIPS, then the minimal number should be lowered for all physician specialties.

The AAFP believes the current proposal for Advancing Care Information has missed the mark in a major way and urges immediate reconsideration.

- Although we believe ACI improves on the requirements of the MU program, the burden of compliance still outweighs the benefit that patients will experience.

The AAFP is shocked and disappointed that the rule fails to provide the option of forming virtual groups for small and solo physician practices.

- With respect to the MIPS pathway, Congress expressly established the ability of solo and small groups to aggregate their data — in an effort to remove any methodology biases due to their potential small number of Medicare beneficiaries — through "Virtual Groups."
- Without the availability of virtual groups, it is highly probable that physicians practicing alone or in small groups will be at a significant disadvantage under MIPS.
- Public Law 114-10 recognized that a majority of physicians practice in a clinical setting that includes five or fewer physicians.
    - In fact, greater than 50% of family physicians currently practice in such a setting
- CMS, in the proposed rule, states that the agency is unable to establish or implement the virtual group option as mandated by Public Law 114-10.
    - This is most unfortunate because not only did the law mandate that these groups be established and made available to solo and small group physicians, but it also eliminates an opportunity for these physicians to participate in an equitable manner in the MIPS program.
- Since virtual groups — which are mandated by law to ensure the viability of solo and small physician practices in the MIPS program — will not be available for such physicians and their practices in the initial performance period, we strongly urge CMS to include an interim pathway to virtual groups, as outlined below, in the final regulation.
- Physician practices with five or fewer physicians, billing under a single TIN, who participate in the MIPS program through the submission of quality data, use of a CEHRT electronic medical record, and participation in clinical practice improvement activities should be exempt from any negative payment updates resulting from the MIPS program until such time that virtual groups — as outlined and mandated by Public Law 114-10 — are readily available

Congress fully supported the medical home and intended for the medical home to be a model recognized as an Advanced APM.

- CMS's failure to make a medical home model available as an Advanced APM would not only violate Congressional intent, but would undercut more than a decade of progressive transformation in primary care practices — not to mention demoralize tens of thousands of primary care physicians.
- We urge CMS to identify a medical home model that can be included as an Advanced APM.

- We recommend that CMS broaden the definition of patient-centered medical home specifically to include programs that have a demonstrated track record of support by non-Medicare payers, state Medicaid programs, employers, or others in a region or state.
- The AAFP strongly urges CMS to consider the inclusion of PCMH recognition programs that accredit based on the advanced primary care functions reflected in the Joint Principles of the Patient-Centered Medical Home (PCMH) and the five key functions of the Comprehensive Primary Care (CPC) Initiative.

The AAFP strongly recommends that CMS remove the entire medical home model financial standard from the proposed rule.

- The AAFP reiterates our strong belief that medical homes should not be subject to any financial risk.
- The AAFP views this as a significant misinterpretation of the law which was designed to protect and foster medical homes.
- The financial standard for the medical home model is an arbitrary imposition of financial risk placed upon clinicians in these models and violates the intent of the law.
- Because the PCMH reduces spending and utilization, imposing risk sharing on the medical home model may be counterproductive and have a dampening effect on adoption of the model.

The AAFP strongly opposes application of the total per-capita cost of care and Medicare Spending per Beneficiary measures to primary care physicians that are not part of an advanced APM.

- Both total cost of care and MSPB were developed to measure hospital performance, and these measures inappropriately attribute costs of patient care that are unrelated to physician practice and particularly, unrelated to primary care practice.
- The AAFP urges CMS to withdraw these measures and instead use care episode-based groups as the sole method of measuring resource use to emphasize high volume and high cost conditions and procedures.
    - Primary care physicians outside advanced APM arrangements cannot anticipate that multiple specialties will work together toward total cost of care reduction and should not be held accountable for these costs, many of which will be generated by specialists.
    - Rather, the physicians who generated the costs should be held responsible for such costs.

The AAFP completely objects to the implementation of the entire section of this proposed rule related to "MIPS APMs."

- This section of the proposed regulation is incredibly confusing and we have concerns that, as written, CMS is incentivizing physicians to remain in the fee-for-service program rather than to continue their progress toward APMs.
- We recommend that CMS allow APMs to sit between Advanced APMs and MIPS — not eligible for the 5 percent Advanced APM bonus, but not subject to the MIPS methodology either for a period of time such as two years.
    - At the completion of this time period, the APM would either have to move into the full Advanced APM program or be subjected to the MIPS criteria as applicable with no special consideration under any of the four categories.