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## MACRA Issues for Physicians in Small Practices

### AMA Podcast: "MACRA Issues for Physicians in Small Practices"

You're listening to a podcast from the American Medical Association to help your practice transition to the new Quality Payment Program that was created by the Medicare Access and CHIP Reauthorization Act, or MACRA. I'm Sandy Marks, Assistant Director of Federal Affairs at the AMA.

This podcast discusses policies that could help physicians in solo, small or rural practices succeed under the new program. Some were included in the policies originally proposed by the Centers for Medicare and Medicaid Services, or CMS. In response to AMA recommendations for many more accommodations for small physician practices, the final policies included a number of improvements.

Here are the basics. The Quality Payment Program provides two pathways. The first is a value-based payment program that works with the Medicare physician fee schedule. It's called MIPS, which stands for Merit-based Incentive Payment System.

MIPS will replace the Physician Quality Reporting System, Value-Based Modifier, and Meaningful Use of electronic health records programs. It also adds a fourth component, Improvement Activities, which is intended to give physicians credit for their efforts to reduce disparities in care, engage patients in shared decision-making, and other activities designed to improve care.

Instead of three separate programs, MIPS is designed to be one cohesive program with a single score for each physician or group. The score will be derived from four components: quality, costs, improvement activities, and advancing care information.

A key benefit of the new law is that potential penalties under MIPS are smaller than combined penalties under the 3 older programs, starting with a limit of 4% on penalties for 2019. In addition, MIPS offers more opportunities for physicians to get positive incentive payments than the older programs.

But what about physicians in small practices? When Congress enacted MACRA, it recognized the unique challenges facing physicians in small and rural practices. For example, the law required CMS to set a low-volume threshold so that physicians who do not treat enough Medicare patients to have a chance at getting a positive return from participating in MIPS would be exempt from it.

MACRA also called for creating virtual groups so that physicians in small and rural practices can combine their resources to jointly report on MIPS measures.

In addition, the law provided \$20 million per year for five years for organizations to provide technical assistance to practices of 15 or fewer that can help these practices succeed under MIPS, or transition to alternative payment models, with priority given to those in rural and medically-underserved areas.

Here at the AMA, we reviewed the MIPS proposed policies in detail and successfully urged CMS to make a number of changes in the final regulations. The AMA told policymakers that some of the most high-value care in this country is delivered by physicians in independent, small practices, so it is important for the MIPS program not to hurt these practices and patients' access to them.

One of the biggest changes CMS made was to raise the low-volume threshold. At the AMA's urging, the final low-volume threshold is triple what was proposed, exempting from MIPS all physicians with less than \$30,000 in Medicare allowed charges or fewer than 100 unique Medicare patients.

We estimated that this policy change would exempt nearly one in 3 physicians from MIPS. CMS concurs, and further estimates that 45% of physicians and other professionals in practices of fewer than 10 clinicians will now be exempt from MIPS due to the low-volume threshold.

The AMA also called for CMS to reduce the minimum requirements for small practices in the Improvement Activities part of MIPS. As we recommended, physicians in small practices can now get full credit in this category for doing one highly-weighted or two medium-weighted activities.

Under the Quality category, CMS changed a measure that looks at all-cause readmissions so that it only applies to physicians in practices of 16 or more clinicians that have a minimum of 200 relevant cases. Originally, the measure would have applied to groups of 10 or more.

CMS also agreed to two other major changes in the year 2017 requirements that apply to all physicians, not just those in small practices. The AMA recommended that 2017, which is the first measurement year for MIPS, be treated as a transitional year so that as few physicians as possible will face MIPS penalties in 2019.

In response, CMS established the "Pick Your Pace" approach. This means that any physician who reports just one measure for one patient at any time during 2017 is guaranteed to avoid a 2019 penalty. As a result, 90% of physicians in practices of fewer than 10 clinicians will have either a neutral or positive payment adjustment in 2019.

We also asked CMS to postpone the cost component of MIPS and give it a zero weight because much of the work that will be needed for appropriate cost measurement has not yet been completed. CMS agreed.

Although the final rule for MIPS adopted many AMA recommendations for year one, it left future policies to be determined later. We are continuing to work for additional changes to help small and rural practices in future years, such as allowing physicians to join together and participate through virtual groups.

We are also urging CMS to maintain a flexible, transitional approach in 2018 similar to the approach that it adopted for 2017 to help physicians avoid penalties and maximize their opportunities for success in MIPS.

Coming back to the Quality Payment Program's two pathways, besides MIPS, the other pathway is participation in alternative payment models, including patient-centered medical homes.

There are two ways for participation in alternative models to help physicians. Physicians can earn 5% annual bonus payments for up to 6 years and be exempt from MIPS altogether if they participate in alternative payment models that meet certain criteria established by CMS. Other models that do not meet these criteria can increase physicians' MIPS scores.

As with MIPS, the AMA's response to CMS' alternative payment model proposals successfully urged more accommodations for physicians in small practices. For example, CMS had only proposed to recognize medical homes accredited by one of four national organizations, but in its final regulation, CMS agreed to recognize medical homes certified by state and local bodies, private payers, and others. Participants in these medical homes receive full credit in the Improvement Activities category.

The Quality Payment Program is intended to promote physician participation in a variety of alternative payment models, but initial proposals allowed very few physicians to be counted as participants in qualified models.

CMS is now allowing more primary care practices to join the Comprehensive Primary Care Plus model, however, and it is offering a new accountable care organization model starting in 2018. The AMA is also urging Medicare to adopt proposals from medical societies for physician-focused payment models so that this pathway will be a viable option for more physicians, including those in small practices.

Thank you for joining us for this AMA podcast on MACRA. To learn more, visit [ama-assn.org/medicare-payment](http://ama-assn.org/medicare-payment).