



MACRA Frequently Asked Questions

Following the release of the Quality Payment Program Interim Final Rule, the American Medical Association (AMA) conducted numerous informational and training sessions for physicians and medical societies. Many questions were asked during these trainings and subsequent conversations, which prompted the AMA to develop the following “Frequently Asked Questions” resource. The AMA notes that these FAQs should not be considered legal advice and that physicians are encouraged to consult their own legal counsel regarding the contents of the document.

General

1. The new administration and Congress are revisiting the Affordable Care Act (ACA) – planning to replace it with something different. What are the chances they will do the same with the Medicare Access and CHIP Reauthorization Act (MACRA)? Is MACRA here to stay?

A. Unlike the ACA, MACRA passed Congress with almost unanimous bi-partisan support. The legislation is seen by those in Congress as separate from the ACA. We therefore think that it will not be subject to overhaul, but the AMA will be working with the new administration and Congress to address any concerns.

2. If MACRA begins in 2017, how come I am hearing about PQRS, MU and VBM reports and appeals for this year?

A. While MACRA reporting can start as early as Jan. 1, 2017, the MACRA incentives and penalties cannot impact physician payment until 2019 — in other words, the Centers for Medicare and Medicaid Services (CMS) is continuing its policy of using a two-year look back period

before awarding penalties and incentives under MACRA. Accordingly, physician Medicare payment in 2017 will still be impacted by performance on pre-MACRA programs — PQRS, MU and VBM – based on performance in 2015. Similarly, 2018 payment will be impacted by PQRS, MU and VBM performance from 2016.

3. There is confusion about what counts toward the \$30,000 low-volume threshold — is it Medicare billings or Medicare allowed charges?

A. It is Medicare allowed charges, which includes the 80% that Medicare pays and the patient’s 20% cost-sharing.

4. When will CMS notify physicians to let you know if you qualify for the 2017 low-volume exemption?

A. CMS was supposed to notify both individuals and groups if they qualify for the low-volume threshold in December 2016, prior to the start of the first MACRA performance period; that plan was delayed and we expect notifications to be made in the first quarter of 2017. During the performance period, CMS intends to conduct another assessment based on claims data from Sept. 1, 2016 to Aug. 31, 2017 to see if additional practices qualify for an exemption and will notify practices next December if they are exempt from the Quality Payment Program (QPP) created by MACRA. Importantly, a practice that is exempt under the early 2017 determination will not have their low-volume status revoked during the second assessment, even if the data show that they have exceeded the low-volume threshold.

5. Are the MACRA benchmarks for the number of patients or total billing determined on a per-physician basis or per-practice basis?

- A. The same low-volume threshold of \$30,000 in allowed Medicare charges or 100 Medicare patients will be applied at either the individual or group level. If a group that has been billing Medicare under a single taxpayer identification number (TIN) would exceed the threshold even though the individual physicians in the group would not, the physicians would only be exempt from the Merit-based Incentive Payment System (MIPS) if they report as individuals instead of as a group.

6. If a practice is reporting as a group, and includes both patient facing and non-patient facing physicians, will the non-patient facing physicians count toward the MIPS components—quality, advancing care information (ACI) and improvement activities metrics?

- A. Yes, the non-patient facing physicians will count towards the group metrics. Non-patient facing physicians are those individuals who bill 100 or fewer patient facing encounters during the non-patient facing determination period (Determination Period), and groups in which more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient facing physician during the Determination Period.

The Determination Period is defined as a 24-month assessment period, which includes a two-segment analysis of claims data regarding patient-facing encounters during an initial 12-month period prior to the performance period, followed by another 12-month period during the performance period.

The Determination Period's initial 12-month segment spans from the last four months of a calendar year two years prior to the performance period to the first eight months of the following calendar year and includes a 60-day claims run out, which will allow CMS to inform physicians and groups of their non-patient facing status during the month (December) prior to the start of the performance period.

For purposes of the 2019 MIPS payment adjustment, CMS has initially identified

individual physicians and groups who are considered non-patient facing physicians based on 12 months of data starting from Sept. 1, 2015 to Aug. 31, 2016. In order to account for the identification of additional individual physicians and groups that may qualify as non-patient facing during the 2017 performance period, CMS will conduct another eligibility determination analysis based on 12 months of data starting from Sept. 1, 2016 to Aug. 31, 2017.

7. What is the advantage of participating as a group vs. individual?

- A. There are advantages to each approach, depending on the composition of your practice. For example, in general, each NPI in a TIN must report on the same measures and will receive the same score. This may be beneficial to some practices and not to others.

8. How does a physician in a multi-specialty group select the measures on which he or she reports?

- A. If a physician in a multi-specialty group is reporting as an individual, he or she may select whichever measures are most applicable to his or her practice. If the members of the multi-specialty practice are reporting as a group, each individual must report on the same measures. As such, the group will need to determine which measures are best for the group.

9. Do you need an electronic health record (EHR) to participate in MIPS?

- A. No, you can still participate in MIPS if you are not using an EHR. However, using federally certified electronic health record technology (CEHRT) will enable you to maximize the number of points need to do well in your overall MIPS composite score.

The ACI component of MIPS counts for 25 percent of your total MIPS score. Participation in the ACI component requires the use of CEHRT. While the other MIPS components, such as quality, cost and improvement activities do not expressly require the use of CEHRT, using an EHR may enable more reporting flexibility and can provide the opportunity for additional bonus points.

Note that if you plan on participating in MIPS as a group, instead of as an individual, the use of

an EHR will affect your group's overall score and reporting capability.

10. Do these policies apply to physicians in

Ambulatory Surgical Centers, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)?

- A. While Ambulatory Surgical Center facilities are paid via the Ambulatory Surgical Center Payment System and not subject to MACRA, the physicians who work in them are subject to MACRA and its payment adjustments.

Conversely, items and services furnished by a physician that are payable under the FQHC or RHC all-inclusive payment methodology (including those physicians providing services for an FQHC or RHC as an employee or contractor) would not be subject to the MIPS payment adjustment. These physicians have the option to voluntarily report on MIPS. Note that if a physician furnishes other items and services in an RHC and/or FQHC and bills for those items and services under the Physician Fee Schedule, the MIPS payment adjustment would apply.

11. Are there advantages to reporting measures for more than 90 days?

- A. Yes. By reporting for more than 90 days, a physician may be more likely to receive an incentive payment. CMS states that the more data they receive, the greater the chance for a larger bonus payment.

12. Is it 90 calendar days or business days?

- A. The 2017 performance period is 90 continuous calendar days.

13. Does a physician report solely on Medicare patients or all patients?

- A. Physicians must report on 50 percent of all patients for the quality category, unless they are reporting via claims, in which case they only need to report on 50 percent of Medicare Part B patients. Physicians must also report on all patients for the ACI category.

14. If a physician has opted out of Medicare, what must he or she do with MIPS?

- A. Physicians who have opted out of Medicare and are privately contracting with their Medicare

patients will not be affected by MIPS and do not need to do anything. Their payments are not affected because they do not accept payments from Medicare. More information about Medicare participation options is available at ama-assn.org/go/medicareoptions.

15. How will physician scores be reported on Physician Compare?

- A. The information mandated for Physician Compare includes the following information:
- The physician's final score
 - The physician's performance under each MIPS performance category
 - Names of physicians in advanced alternative payment models (APM) and, to the extent feasible, the names of such advanced APMs and the performance of such models
 - Aggregate information on MIPS, posted periodically, including the range of final scores for all MIPS-eligible clinicians and the range of the performance of all MIPS eligible clinicians for each performance category

Physicians will have 30 days to review the measurement performance data that will appear on the website in advance of publication. All data available for public reporting – measure rates, scores and attestations – would be available for review and correction during the targeted review process, which would begin at least 30 days in advance of the publication of new data. Data under review will not be publically reported until the review is complete.

Quality

16. How do hospital-based physicians report on quality measures, considering these physicians do not have long-term patient relationships (e.g., radiologists, anesthesiologists, hospitalists, pathologists, E.R. physicians, non-invasive cardiologist who only interprets ECGs and echos)?

- A. Many of the hospital-based physicians in the specialties mentioned above will be considered non-patient facing physicians, who will have reduced requirements within the MIPS program. Non-patient facing physicians are defined as those who have 100 or fewer patient-facing encounters during a period prior to the performance period. For the quality

performance category, while all physicians are required to report six measures or a specialty measure set, CMS notes that they will reweight any performance category if there are not sufficient measures for a MIPS physician, and that they assume many non-patient facing physicians will not have sufficient measures to report and therefore will not be scored on the quality performance category under MIPS. There is also a reduced reporting requirement for non-patient facing physicians in the improvement activities performance category (1 high-weighted versus 2 medium-weighted activities instead of 2 high-weighted or 4 medium-weighted activities). In addition, under the ACI performance category, a physician is determined to be hospital-based if they furnish 75 percent or more of their services in inpatient hospitals, emergency departments or on campus outpatient departments (as determined by place-of-service codes). Physicians who qualify as hospital-based physicians will be excluded from the ACI performance category.

17. Is there any way for specialists within a multispecialty group (whose quality metrics may not be part of the larger group reporting) to assure they won't be closed out of MIPS benefits in the future?

- A. If an individual is a part of group that has chosen to report as a group under their TIN number, then all the data from each individual will be accumulated and reported on in total. For example, if the group chooses to report the medication reconciliation quality measure, the numerator and denominators for all physicians within the group's TIN would be combined for that measure. The entire group would need to choose the same six quality measures to report. It is true the group may choose measures that do not apply to a specialty physician within the group. However, MIPS penalty and incentive payments will be made at the TIN level to the entire group for items and services furnished by all physicians in the group, regardless of which physicians' patients were included in each measure.

18. Will the Group Practice Reporting Option (GPRO) quality measures be used for groups? Will the comparison group be all the reporters' measures or only other GPRO reporters?

- A. If you are referring to the CMS Web Interface measures, then yes, any group of 25 or more who chooses to report via the CMS Web Interface may continue to do so. Otherwise, groups reporting quality measures may select whichever quality measures they choose. The benchmark comparison is divided by submission method, so physicians will be compared to other physicians who submit data via the same method.

19. Success of quality programs depend on robust registries. What is the AMA doing to aggressively combat the data blocking that proprietary EHRs are placing as obstacles to improving quality?

- A. The AMA takes this concern very seriously and is actively engaged with federal policymakers to prevent EHR data blocking. Due the AMA's advocacy efforts, recent changes have been made to the federal government's EHR certification program to promote transparency in the fees vendors charge to connect to registries. The government has also expanded its authority to intervene on behalf of physicians when EHRs no longer conform to certification requirements.

New legislation was recently passed to require EHRs to be capable of transmitting and receiving data from registries, along with monetary penalties for EHR vendors who are found to be blocking patient health information. The AMA will be advising the federal agencies charged with implementing these new laws.

20. What cross-cutting measures must a physician report?

- A. CMS eliminated the requirement that all physicians report on a cross-cutting measure.

21. Must one of the six measures be an outcome measure?

- A. Yes, of the quality measures a physician reports on, one must be an outcome measure or, if no outcome measures are available, a high-priority measure. A high-priority measure is defined as a measure related to appropriate use, patient safety, efficiency, patient experience or care coordination. If a physician reports on additional high-priority quality measures beyond the one required high-priority/outcome measure, they have the potential to receive up to a 10 percent bonus.

22. Where do I find a list of measures?

- A. Quality measures, ACI measures and the list of improvement activities may be found at <https://qpp.cms.gov/measures/performance>.

23. How do you report quality measures under MIPS?

- A. Individuals reporting on quality measures may be reported through claims, a qualified clinical data registry (QCDR), a qualified registry or an EHR. Groups may report quality measures through the following mechanisms:
- QCDR
 - Qualified registry
 - EHR
 - CMS Web Interface (groups of 25 or more)
 - CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism)
 - Administrative claims (for all-cause hospital readmission measure – no submission required)

Recognizing the cost to report through electronic sources, CMS provides a bonus of up to 10 percent of the denominator of the quality performance category score to physicians who report quality measures through an EHR, qualified registry, qualified clinical data registry (QCDR) or web interface (“end-to-end reporting”).

End-to-end reporting essentially requires a physician to use automated software to aggregate measure data, calculate measures, perform any filtering of measurement data, and submit the data electronically to CMS using CMS’ specified submission method. Any submission pathway that involves manual abstraction and reentry of data elements that are captured and managed using certified health IT is not end-to-end electronic quality reporting and is not consistent with the goal of the bonus.

Reporting through the QCDR will also assist with satisfying the improvement activities category.

Cost**24. If a practice has imaging or lab services, then the doctor’s NPI is assigned that cost. Doctors who rely on a hospital for these services do not have this cost assigned. Is this separated out on cost of care in MACRA?**

- A. Physicians should bear in mind that CMS is not counting the cost performance category in a physician’s MIPS score in 2017. That said, if the patient is attributed to you, all of the costs, including lab, imaging, hospital care, etc., will be included, no matter where the services were provided. Different measures will include different types of costs and have different rules for attributing. (For example, one measure covers total Part A and Part B costs for the whole year and attributes those costs to the physician with a plurality of E&M codes; another covers costs from 3 days prior to a hospital admission to 30 days after discharge and attributes all the Part A and B costs during that time to the physician with the highest allowed charges during the admission.) Under episode measures, the costs to be included and the method of attribution will depend on the type of episode involved. More than one physician can be held responsible for the total cost of the episode.

25. How do physicians report under the “cost” component of MIPS?

- A. No data submission is required for the cost category. CMS calculates the cost component from a physician’s claims.

Advancing care information (ACI)**26. Are computerized physician order entry (CPOE) and clinical decision support (CDS) still required under ACI?**

- A. No. CMS has removed the CPOE and CDS measures from ACI and the Meaningful Use program. While CPOE and CDS functionality will still be included in EHRs, CMS will no longer require a certain number of orders, that a physician enter the orders, and that physicians implement a certain number of CDS tools. This means that as of Jan. 1, 2017, physician practices are free to develop policies around CPOE and CDS in ways that blend with their workflows and improve care.

Improvement activities (IA)

27. Some of the details about the 90 improvement activities are unclear. For example, what does CMS mean by completing the AMA Steps Forward modules?

- A. The AMA is seeking additional guidance from CMS on how to obtain IA credit for Steps Forward and other activities.

28. How do you report an IA activity under MIPS?

- A. Reporting will be done via attestation. CMS stated in the Interim Final Rule that it will provide technical assistance through subregulatory guidance to further explain how physicians will report on IAs.

APMs

29. Isn't it likely that MACRA will collapse under its own weight? APM experiments such as Pioneer ACOs failed to achieve meaningful savings and doesn't that point to MACRA's failure overall?

- A. MACRA established a new advisory committee specifically aimed at fostering the development of physician-focused APMs proposed by stakeholders, such as specialty societies, and many specialties are working on new models. MACRA does not require physicians to transition into APMs, but it does provide significant incentives to those who choose to do so.

30. Could you explain the Medicare Shared Savings Program ACO new Track 1 +?

- A. Because the MACRA regulations do not permit Track 1 ACO participants to be eligible for the 5 percent bonus payments and other incentives provided to qualified APM participants under MACRA, several stakeholder organizations proposed the creation of a new ACO track that would involve less financial risk than the existing ACO Tracks 2 and 3, but would qualify for advanced APM status under MACRA. The design of Track 1+ incorporates several AMA recommendations, including allowing the maximum loss threshold to be based on 8% of the ACO's Medicare revenues if the ACO is physician-led, instead of a percentage of the total cost of care for the ACO's patients. Notices of intent to apply for the new ACO track are requested by May 2017 for a start date in 2018.

31. How will CMS exclude certified Medical Homes from MIPS reporting (e.g., private insurers and medical homes)?

- A. Certified medical homes are not excluded from MIPS reporting, but they will receive the full score for the improvement activity component solely for being a medical home.