Frequently Asked Questions

What is MACRA?

The Medicare Access and CHIP Reauthorization Act of 2105 (MACRA) establishes new Medicare payment options for physician services provided under Medicare Part B. The rule becomes effective January 1, 2017.

How does the law effect Medicare payments?

- MACRA repeals the Medicare sustainable growth rate (SGR) formula that often calculated payment cuts for physicians.
- Creates a new framework for rewarding physicians for providing higher quality care by establishing two tracks for payment:
    - Merit-based Incentive Payment System (MIPS), and
    - Alternative Payment Models (APMs)
- Consolidates three existing quality reporting programs (Physician Quality Reporting System, Value-based Payment Modifier, and meaningful use), plus adds a new performance category, into a single system through MIPS.

What is the Merit-based Incentive Payment System (MIPS)?

The Merit-based Incentive Payment System (MIPS) consolidates three existing quality-reporting programs: the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VBPM), and meaningful use (MU). The system also adds a new performance category, called clinical practice improvement activities (CPIA). The four categories establish a composite performance score (0-100) that will be compared against a threshold and then used to determine physician payment adjustments. The categories that make up the MIPS score are:

- Quality – based on PQRS;
- Resource use – based on VBPM;
- Advancing Care Information (ACI) – based on MU; and
- Clinical practice improvement activities – new performance category.

What are the reporting requirements for each category under MIPS?

Quality

- In the Quality performance category, you must report at least six measures, including one cross-cutting measure and one outcome measure. Measures previously available under the PQRS program will be available in the Quality category of MIPS.
- CMS has proposed to calculate and report three population claims-based measures for clinicians. These measures include the acute and chronic composite measures for ambulatory care sensitive conditions (ACSC) and total all-cause hospital readmissions. All-cause hospital readmissions will only apply to groups of 10 or more eligible clinicians. These measures were previously included in the VBPM program.

Resource Use

- There is no reporting requirement for the eligible clinician under the Resource Use category. CMS will calculate the clinician's performance using claims data. As currently proposed, primary care will be predominantly measured on Medicare spending per beneficiary (MSPM) and total cost of care. These measures were previously included in the VBPM program.

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Clinical Practice Improvement Activities (CPIA)

Patient-centered medical homes (PCMH) will automatically receive full credit in the CPIA category. Organizations which currently offer PCMH accreditation include:

- National Committee for Quality Assurance (NCQA)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- Joint Commission (previously called the Joint Commission on Accreditation of Healthcare Organizations)
- URAC (previously called the Utilization Review Accreditation Commission)

Clinicians who do not qualify for the automatic full credit must attest to three high-weighted or six low-weighted activities, or a combination of both to achieve a total of 60 points. CMS has proposed a list of more than 90 CPIAs. An activity must be performed for at least 90 days during the performance period to receive credit.

Advancing Care Information (ACI)

- As proposed, clinicians will receive a base score and performance score in the ACI performance category. The base score accounts for 50 percent of the ACI performance category score and clinicians can earn the additional 50 percent through their performance score.
- For the base score, clinicians must report a numerator (of at least one) and denominator, or yes or no (only yes would qualify for credit) for each measure within a subset of objectives. Failure to meet the submission criteria for any of the measures would result in a zero for the ACI performace category score. The objectives and measures are based on the 2015 EHR Incentive Program requirements. In 2017, a clinician can use the 2014 edition of certified EHR technology (CEHRT), 2015 CEHRT, or a combination. All clinicians must be on the 2015 edition of CEHRT beginning with the 2018 performance period.

How is MIPS scored?

Scores for each performance category will be weighted and rolled up into the composite performance score (CPS). The weights of each category shifts over the course of the program.

What if I don't have an EHR?

Clinicians without an EHR can still participate in MIPS, but will not be eligible for any of the points under the ACI performance category.

While still possible, the reporting requirements will be more burdensome without the use of an EHR. The reporting mechanisms available to a practice without an EHR would be claims or qualified registry. However, use of the qualified registry option would require a manual data collection process. As proposed, this would require reporting on at least 90 percent of the clinician's denominator-eligible patients.

How would I be paid under MIPS?

According to the current legislation, beginning in 2019, physicians participating in MIPS will be eligible for positive or negative Medicare payment adjustments that start at four percent and gradually increase to nine percent in 2022. Distribution of payment adjustments will be made on a sliding scale and will be budget neutral. Payment adjustments will be based on the following:

- Physicians who score at the threshold will receive no payment adjustment.
- Physicians whose composite score is above the threshold will receive a positive payment adjustment on each Medicare Part B claim for the following year.

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- Physicians whose composite score is below the threshold will receive a negative payment adjustment on each Medicare Part B claim for the following year.
- Physicians whose composite score is in the lowest quartile will automatically be adjusted to the maximum negative adjustment on each Medicare Part B claim for the following year.

Since physicians in the lowest quartile will receive the maximum negative adjustment to maintain budget neutrality, physicians with higher composite scores may be eligible for a positive payment adjustment up to three times the baseline positive payment adjustment for a given year. For example, the baseline positive payment adjustment for 2019 will be four percent, so higher performers may be eligible for a positive payment adjustment of up to 12 percent.

For 2019 through 2024, an additional sliding scale positive payment adjustment of up to 10 percent will be available to "exceptional" performers. "Exceptional" performers must meet an additional performance threshold that will be set by CMS. This additional positive payment adjustment does not fall under the budget-neutrality requirements.

Beginning in 2026, all physicians participating in MIPS will be eligible for a 0.25 percent increase in their Medicare Part B physician fee schedule (PFS) payments each year.

Who is exempt from MIPS reporting?

- Providers in their first year billing Medicare;
- Providers whose volume of Medicare payments or patients fall below the proposed threshold (100 patients AND $30,000 or less in Medicare Part B charges); and
- Providers who qualify for payment under APMs with the associated bonuses exempt from MIPS.

What is an Alternative Payment Model (APM)?

MACRA defines any of the following as a qualifying Alternative Payment Model (APM):

- An innovative payment model expanded under the Center for Medicare & Medicaid Innovation (CMMI), with the exception of Health Care Innovation Award recipients;
- A Medicare Shared Savings Program (MSSP) accountable care organization (ACO);
- Medicare Health Care Quality Demonstration Program or Medicare Acute Care Episode Demonstration Program; or
- Another demonstration program required by federal law.

In order for a provider to receive a bonus payment through an APM, the qualified APM must also meet the following eligibility requirements:

- Use of quality measures comparable to measures under MIPS;
- Use of a certified electronic health record (EHR) technology; and
- Assumes more than a "nominal financial risk" **OR** is a medical home expanded under the CMMI.

A physician receiving the designated percentage of Medicare payments or patients through a qualified, eligible APM based on the above requirements is considered a "qualifying participant" (QP).

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How would I be paid under an APM?

If you are a QP, from 2019 through 2024, you will receive an annual five percent lump-sum bonus based on your Medicare Part B payments. This bonus will be in addition to the incentive paid through existing contracts with the advanced APM. Beginning in 2026, you will qualify for a 0.75 percent increase in your Medicare Part B PFS payments each year.

How do I know if I'm in MIPS or an APM?

Most physicians will move through MIPS until more AAPMs become available. If you are interested in the APM model you should still be prepared to start in the MIPS program.