## AAFP Guidance on MACRA Basics

# FAQ on MACRA and Medicare Payment Reform

## Frequently Asked Questions: Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

### What is the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)?*

At a very high level, MACRA:

- Repeals the flawed Medicare sustainable growth rate (SGR) formula that 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
  - Advanced Alternative Payment Models (AAPMs); and

- Consolidates three existing quality reporting programs [Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VBPM), and meaningful use (MU)], plus adds a new performance category, called improvement activities (IA), into a single system through MIPS.

The AAFP has created an introductory, on-demand series for members to provide an overview of the Quality Payment Program (QPP) and how it will affect your practice. **Watch the series now » http://www.aafp.org/practice-management/payment/medicare-payment/webcasts.html**

### What is the Quality Payment Program (QPP) and how does it relate to MACRA?+

The Quality Payment Program (QPP) is the umbrella term used to describe the MIPS and AAPM tracks under MACRA.

## 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 improvement activities (IA). Scores from the four categories are combined to establish a final score (0-100) that will be compared against a threshold. The final score is then used to determine physician payment adjustments. The categories that make up the MIPS final 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.

AAFP members can watch a short primer on MIPS, titled "MACRA: An Overview of the Merit-based Incentive Payment System (MIPS)." **Watch the on-demand module now »**

## How will I be scored under MIPS?*

Scores for each performance category will be weighted and rolled up into the MIPS final score. The weights of each category shift over the course of the program.

| PERFORMANCE CATEGORY | 2019 | 2020 | 2021 |
|---|---|---|---|
| Quality | 60% | 50% | 30% |
| Cost | 0% | 10% | 30% |
| ACI | 25%* | 25%* | 25%* |
| IA | 15% | 15% | 15% |

*If the Secretary of the U.S. Department of Health and Human Services (HHS) determines the proportion of eligible clinicians who are “meaningful users of electronic health records (EHRs)” is estimated at 75% or greater, the weight of the ACI category may be reduced. The remaining performance categories will be increased by the corresponding number of percentage points. The lowest weight the ACI category can carry is 15%.

## Who am I compared to?

All MIPS-eligible clinicians (ECs), regardless of specialty, will be compared to each other and against a performance threshold.

## What if I am in a large multispecialty group?+

ECs in a large multispecialty group can report either as an individual or as a group. When reporting as a group, all ECs reporting under the group's tax identification number (TIN) will be included. A group cannot have some ECs report as a group and others report as individuals. Under the group reporting option, all ECs will report on the same measures. If you choose to report as a group, you must report as a group across all four MIPS performance categories.

## What are the reporting methods?+

Reporting methods for individuals include: claims, qualified clinical data registry (QCDR), qualified registry, and electronic health records (EHR). The ACI and IA categories will include attestation options. There is no data submission for the cost performance category, as the Centers for Medicare & Medicaid Services (CMS) will calculate this for ECs based on Medicare claims data.

Reporting methods for groups include: QCDR, qualified registry, EHR, CMS Web Interface, and CMS-approved survey vendor for the Consumer Assessment of Health Providers and Surveys (CAHPS) for MIPS. Groups will also be able to attest for the ACI and IA performance categories. The CMS Web Interface option is only available to groups of 25 or more ECs.

## What are the reporting requirements under MIPS?*

### *Quality*

In the quality performance category, you must report at least six measures, including one outcome measure. Measures previously available under the PQRS program will be available in the quality category of MIPS.

In addition to the six measures reported by ECs, CMS will calculate the all-cause hospital readmissions measures for groups of 16 or more ECs. This measure was previously included in the VBPM program.

### *Cost*

There is no reporting requirement for ECs under the cost category. CMS will calculate the clinician's performance using claims data. During the transition year (2017), the cost performance category has been reweighted to 0%. Beginning with performance year 2018 (for payment year 2020), clinicians will be assessed on their performance of total per capita costs and Medicare spending per beneficiary (MSPB). Clinicians will also be assessed on applicable episode-based measures. To help clinicians become familiar with cost measures, CMS will provide feedback on these measures during the transition year.

To understand your previous performance compared to current national performance in quality and cost, review your Quality and Resource Use Report (QRUR).

### *Improvement Activities (IA)*

Patient-centered medical homes (PCMH) will automatically receive full credit in the IA category. Organizations which currently offer approved 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)
- State-based, regional, private payers, or other entities that administer PCMH accreditation to at least 500 practices

Additionally, if one practice under the TIN has PCMH recognition, the entire TIN will qualify for full points with the IA performance category.

Clinicians who do not qualify for the automatic full credit must attest to two high-weighted (20 points each) or four medium-weighted (10 points each) activities, or a combination of both to achieve a total of 40 points. CMS has a list of more than 90 improvement activities. An activity must be performed for at least 90 days during the performance period to receive credit.

In order to ease the burden for small practices (15 or fewer ECs), practices in rural areas or health professional shortage areas (HPSAs), CMS is only requiring submission of one high-weighted activity or two medium-weighted activities.

If you are an EC that is an APM, but not a MIPS APM, you will receive half the credit for the IA performance category.

For MIPS APMs, CMS will assign a score in the IA performance category based on IA requirements under the terms of the particular MIPS APM. If CMS assigns the maximum score, then MIPS APM participants would not need to submit additional activities. If the MIPS APM does not receive the maximum score, the participants would have the opportunity to submit additional activities to be added to the baseline score assigned to CMS.

### *Advancing Care Information (ACI)*

ECs will receive a base score and performance score in the ACI performance category. The base score accounts for 50% of the ACI performance category score and clinicians can earn the additional 50% through their performance score. An EC cannot earn more than 100 points (100%) in the ACI performance category.

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 required measure within a subset of objectives. Failure to meet the criteria for any of the base score measures would result in a zero for the base score and ultimately a zero for the entire ACI performance category score.

If the base score is achieved, the performance score enables clinicians to earn up to 50 points (based on their performance rate) toward their overall ACI performance category score.

The objectives and measures are based on the 2015 EHR Incentive Program requirements. In 2017, a clinician can use 2014 edition certified EHR technology (CEHRT), 2015 edition CEHRT, or a combination of the two. All clinicians must be on the 2015 edition of CEHRT beginning with the 2018 performance period.

Clinicians using EHRs certified to either the 2014 or the 2015 edition can report on the following objectives and measures:

| 2017 ADVANCING CARE INFORMATION TRANSITION OBJECTIVE (2017 ONLY) | 2017 ADVANCING CARE INFORMATION TRANSITION MEASURE (2017 ONLY) | REQUIRED/NOT REQUIRED FOR BASE SCORE | PERFORMANCE SCORE | REPORTING REQUIREMENT |
|---|---|---|---|---|
| Protect Patient Health Information | Security Risk Analysis | Required | 0 | Yes/No Statement |
| Electronic Prescribing | e-Prescribing | Required | 0 | Numerator/Denominator |
| Patient Electronic Access | Provide Patient Access | Required | Up to 20% | Numerator/Denominator |
| | View, Download, or Transmit (VDT) | Not Required | Up to 10% | Numerator/Denominator |
| Patient-specific Education | Patient-specific Education | Not Required | Up to 10% | Numerator/Denominator |

| | | | | |
|---|---|---|---|---|
| Secure Messaging | Secure Messaging | Not Required | Up to 10% | Numerator/Denominator |
| Health Information Exchange | Health Information Exchange | Required | Up to 20% | Numerator/Denominator |
| Medication Reconciliation | Medication Reconciliation | Not Required | Up to 10% | Numerator/Denominator |
| Public Health Reporting | Immunization Registry Reporting | Not Required | 0 or 10% | Yes/No Statement |
| | Syndromic Surveillance Reporting | Not Required | Bonus | Yes/No Statement |
| | Specialized Registry Reporting | Not Required | Bonus | Yes/No Statement |

Clinicians using technology certified to the 2015 edition can report the following objectives and measures.

| ADVANCING CARE INFORMATION OBJECTIVE | ADVANCING CARE INFORMATION MEASURE | REQUIRED/NOT REQUIRED FOR BASE SCORE | PERFORMANCE SCORE | REPORTING REQUIREMENT |
|---|---|---|---|---|
| Protect Patient Health Information | Security Analysis | Required | 0 | Yes/No Statement |
| Electronic Prescribing | e-Prescribing | Required | 0 | Numerator/Denominator |

| | | | | |
|---|---|---|---|---|
| Patient Electronic Access | Provide Patient Access | Required | Up to 10% | Numerator/Denominator |
| | Patient-specific Education | Not Required | Up to 10% | Numerator/Denominator |
| Coordination of Care through Patient Engagement | View, Download, or Transmit (VDT) | Not Required | Up to 10% | Numerator/Denominator |
| | Secure Messaging | Not Required | Up to 10% | Numerator/Denominator |
| | Patient-Generated Health Data | Not Required | Up to 10% | Numerator/Denominator |
| Health Information Exchange | Send a Summary of Care | Required | Up to 10% | Numerator/Denominator |
| | Request/Accept Summary of Care | Required | Up to 10% | Numerator/Denominator |
| | Clinical Information Reconciliation | Not Required | Up to 10% | Numerator/Denominator |
| Public Health and Clinical Data Registry Reporting | Immunization Registry Reporting | Not Required | 0 or 10% | Yes/No Statement |
| | Syndromic Surveillance Reporting | Not Required | Bonus | Yes/No Statement |

| | | | | |
|---|---|---|---|---|
| | Electronic Case Reporting | Not Required | Bonus | Yes/No Statement |
| | Public Health Registry Reporting | Not Required | Bonus | Yes/No Statement |
| | Clinical Data Registry Reporting | Not Required | Bonus | Yes/No Statement |

## Can I participate in MIPS without 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. Use of EHR technology that is not certified will result in a zero for the category.

While still possible to participate in MIPS without an EHR, 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. This would require reporting on at least 50% of the clinician's denominator-eligible patients.

## How will I be paid under MIPS?*

Beginning in 2019, physicians participating in MIPS will be eligible for positive or negative Medicare Part B payment adjustments that start at 4% and gradually increase to 9% 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 with a final score at the threshold will receive a neutral payment adjustment.
- Physicians with a final score above the threshold will receive a positive payment adjustment on each Medicare Part B claim in the payment year.
- Physicians with a final score below the threshold will receive a negative payment adjustment on each Medicare Part B claim in the payment year.
- Physicians with a final score in the lowest quartile will automatically be adjusted to the maximum negative adjustment on each Medicare Part B claim in the payment year.

The 2017 MACRA final rule designated 2017 a transition performance year and set the performance threshold at three points. As a result, any level of participation through the **Pick Your Pace** program will protect an EC from the 2019 negative payment adjustment. Since physicians in the lowest

quartile will receive the maximum negative adjustment, to maintain budget neutrality, physicians with higher final 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 4%, so higher performers may be eligible for a positive payment adjustment of up to 12% (4% x 3).

For 2019 through 2024, an additional sliding scale for a positive payment adjustment of up to 10% will be available to “exceptional performers.” For transition year 2017, the threshold for “exceptional performers” is 70 points. 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% increase in their Medicare Part B physician fee schedule (PFS) payments.

## How is the payment adjustment applied?+

CMS will apply the MIPS payment adjustment at the TIN/National Provider Identifier (NPI) level. ECs who reported as a group, will all receive the same final score, but the payment adjustment will be applied at the TIN/NPI level.

## What if I change groups during the performance period?+

If an EC bills under more than one TIN during the performance period, CMS will use the highest final score associated with the clinician’s NPI during the performance period.

If a clinician changes TINs between the performance period and payment year, CMS will apply the final score associated with the clinician’s NPI during the performance period to the new TIN/NPI combination. For example, if a clinician practiced at TIN A during the performance period, but is practicing at TIN B during the payment year, CMS will use the final score from TIN A to apply to the payment adjustment to the new TIN B.

## Are there any exemptions from MIPS?

Yes. Exemptions from MIPS include:

- Clinicians in their first year billing Medicare;
- Clinicians with their volume of Medicare payments or patients falling below the low-volume threshold (100 Medicare patients OR $30,000 or less in Medicare Part B charges); and
- Clinicians who qualify for a bonus payment under AAPMs.