MACRA FAQs

Frequently Asked Questions to Help Ophthalmic Practices Understand MACRA

The Medicare Access and CHIP Reauthorization Act (MACRA) is instituting the biggest change to Medicare physician payment in decades. With reporting for MACRA beginning in 2017, ASCRS•ASOA has collected questions we have received from members and made them available to assist ophthalmic practices as they prepare to transition into the new Medicare Quality Payment Program.

- **What is MACRA?**

  Enacted in April 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) repealed the flawed Sustainable Growth Rate and replaced it with a value-based reimbursement system referred to as the Quality Payment Program (QPP), which includes the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMS). In addition, MACRA sunsets the penalties of the current quality reporting programs—PQRS, the Value-Based Payment Modifier, and Meaningful Use—in 2018 and incorporates the programs into MIPS, along with a new category, Improvement Activities. MACRA also includes five years of modest, but positive 0.5% updates, which began in 2015.

- **How will MACRA impact Medicare payments?**

  From 2015 through 2019, all physicians will receive a 0.5% update each year. From 2020 forward, MACRA payments will be based on the participation of an individual provider or practice in the new QPP.

- **When does MACRA start?**

  The MACRA statute requires Medicare physician payments to be based on the new Quality Payment Program (QPP) beginning in 2019. In addition, there is a statutory update of 0.5% through 2019. CMS requires physicians to submit data through the MIPS program beginning in 2017 to impact payments in 2019. Following advocacy from ASCRS•ASOA and the medical community, CMS is offering flexible performance period options, what CMS terms “Pick Your Pace” in the first year.

  To avoid a penalty for 2019, beginning January 1, 2017, providers can choose to report either:

  - **One quality measure for one patient, and not have to meet the measure benchmark, or**
  - **One improvement activity, or**
  - **The required base measures for Advancing Care Information.**

To be eligible for a small bonus and avoid a penalty, providers can choose to report for at least 90 days:

- **Two or more quality measures on at least one patient, and not have to meet the measure benchmarks, or**
- **More than one improvement activity, or**
- **The required base measures and additional performance measures for Advancing Care Information.**

Providers who report all the required measures and meet thresholds and benchmarks in each of the categories for at least 90 days—or up to the full year—have the greatest potential for a larger bonus and will not receive a penalty. The 90-day performance period can begin anytime between January 1, 2017, and October 2, 2017. Data must be reported no later than March 31, 2018.

- If a MIPS-eligible clinician does not report even one measure or activity in 2017, he or she will receive the full negative 4% payment adjustment in 2019.
- MIPS eligible clinicians who participate in Advanced APM entities that meet the required revenue or patient thresholds will receive a 5% bonus.

- **What is MIPS?**

MIPS incorporates aspects of the three existing quality reporting programs (Physician Quality Reporting System, EHR Meaningful Use, and Value-Based Payment Modifier) into one program, adding an additional category: Improvement Activities. MIPS will assess performance based on four categories: Quality, Resource Use, Advancing Care Information, and Improvement Activities. Physicians must meet specific requirements for each of the categories and will receive a weighted final score. The final score will be compared to an overall performance threshold score to determine a physician's payment adjustment for the year. Physicians with composite scores above the benchmark will receive a bonus; those scoring below it will receive a penalty; and those at the benchmark score will receive no payment adjustment.

For the first performance year, CMS has set a performance threshold of 3. Any MIPS final score at the threshold will not receive a penalty. MIPS final scores above the threshold are eligible for a bonus. Any score below the threshold will receive the full 4% penalty. CMS has set a score "floor" for any quality measure of 3; therefore, to coincide with the performance period flexibility mentioned above, reporting one quality measure on one patient will result in a MIPS final score of 3, and allow the provider to avoid a penalty. MIPS scores above 70 qualify for the exceptional performance bonus, which comes from funds that were set aside for this purpose.

- **Will I participate as an individual or a group?**

Under the MIPS track, physicians have the option to report performance data as individuals or as a group. While physicians may choose whichever option works best for them, all data for each of the four categories must be reported consistently as a group or an individual. This means, if a physician reports as an individual for the Quality category, he or she must also report as an individual for the remaining performance categories: Resource Use, Advancing Care

Information, and Improvement Activities. Conversely, a group of physicians reporting on Quality data would also have to report the data from the remaining categories as a group.

Under the Advanced APM option, individual physicians must be determined to be a "qualified participant" (QP) to receive the 5% yearly bonus; however, the determination for being a QP is made for all participants in the APM entity, such as a Track 2 or 3 ACO or medical home. Individual physicians can choose to participate in an Advanced APM entity, but will not receive the bonus unless all the participants in the entity collectively meet the patient or revenue thresholds for a particular year. Individual physicians in a group practice may choose to participate in a particular Advanced APM, but not all providers in the group practice must participate. If a physician participates in more than one Advanced APM, CMS will determine if an individual physician is a QP from participation in one, or a combination of several, Advanced APMs. See additional FAQs for information on what qualifies as an Advanced APM.

- **How will the four reporting categories under MIPS be weighted?**

  CMS will weight the four performance component categories as follows for the first performance period:

  - Quality: 60%
  - Resource Use: 0%
  - Advancing Care Information: 25%
  - Improvement Activities: 15%

  ASCRS•ASOA successfully advocated for the Resource Use category to be weighted at 0% of the MIPS final score for the first year. However, CMS will still calculate the Resource Use measures for informational purposes. In 2018, the Resource Use category will be weighted at 10% and 30% in 2019.

- **Where can I find the requirements for each of the MIPS categories?**

  ASCRS has developed in-depth guides on each of the four categories of MIPS. These guides outline the specific requirements for reporting and how each category will be scored and weighted. The guides are specifically designed to assist ophthalmic practices in navigating the new program. The guides are available for ASCRS•ASOA members on the ASCRS website's MACRA Implementation Center at ascrs.org/macracenter.

- **What are the bonuses and penalties under MIPS?**

  The "Pick Your Pace" performance period options for 2017 allow physicians to submit some data and avoid a penalty in 2019. If a provider does not submit any MIPS data, he or she will be assessed the full -4% penalty in 2019 set in the MACRA statute. MACRA sets the bonus at up to 4% for the first year. However, since payment adjustments must be budget neutral—the total amount of penalties is redistributed as bonus payments—and CMS has made it very easy to avoid a penalty, it is unlikely there will be much money available to redistribute as bonuses in 2019. Physicians scoring at 70 or above are eligible for the exceptional performance bonus, which comes from separate funds not subject to the budget neutrality requirements.

For the following years, penalties will be capped at: -5% in 2020, -7% in 2021, and -9% in 2022. Bonuses for each of the years are up to three times the annual cap for each year's penalty—with the potential for additional bonuses of 10% for exceptional performance. Under MIPS, bonuses and penalties will be awarded in a linear system. Only physicians with the highest or lowest composite scores will receive the maximum possible bonus or penalty. Any physician scoring above the threshold has the opportunity to be awarded a bonus, but the amount will depend on how close or far the score is to the threshold. The same system applies for penalties: the lower the composite score, the higher the penalty—except in the first year where the only providers receiving a penalty will be those who did not submit anything, and they will receive the full 4%. It is important to remember that under the pre-existing law, potential penalties would have been -11% in 2019, and the only bonus potential was from the Value-Based Payment Modifier.

- **Is MIPS budget neutral?**

  Under the MACRA statute, the MIPS program is designed to be budget neutral. In accordance with the Quality Payment Program, bonuses are rewarded to high-performing providers and are paid for by the penalties of "non-performing" providers. However, the flexibility for 2017 reporting may limit the potential bonus for payment year 2019 due to the issue of budget neutrality and the lack of money to pay for such increases. It is likely that fewer bonuses will be awarded, and they will be smaller compared to the bonuses originally outlined in MACRA.

- **What are Advanced APMs?**

  Under MACRA, physicians will receive a 5% bonus to Medicare physician payments for participating in certain advanced APMs. To qualify as an advanced APM, the model must incorporate quality measures, the use of EHR technology, and have two-sided risk. To receive the 5% bonus, the collective participants in the advanced APM entity must meet yearly thresholds for the percentage of patients or revenues covered by the APM. For 2019 payment, based on 2017 performance, 25% of Medicare revenues or 20% of Medicare patients must be from an APM. Beginning in 2021, CMS will allow non-Medicare patients and revenues to be included toward the thresholds; however, the thresholds continue to increase, up to 75% of revenues or 50% of patients by 2023.

- **What Advanced APMs are available for ophthalmologists? How do I know if I participate in one?**

  There are currently no ophthalmology specific advanced APMs. In addition, current available models are, for the most part, focused on primary care, such as ACOs or certified medical homes. Some ophthalmologists currently participate in Medicare Shared Savings Program Track 1 ACOs, but since those models do not include two-sided risk, they are not considered advanced APMs, and will not be eligible for bonus payments. In addition to the requirement for two-sided risk, advanced APMs must also include quality and EHR components. **If you participate in an APM, such as an ACO, be sure to contact the organization for specific information regarding that entity's requirements and planned participation for 2017.**

- **I participate in a Track 1 ACO. Can I earn credit for MIPS?**

  Physicians may also earn points in MIPS by participating in certain APMs and Advanced APMs that CMS determines to be "MIPS APMs." For 2017, CMS has determined Track 1 ACOs are considered MIPS APMs. For physicians participating in Track 1 ACOs:
  - **Report the required quality measures for the APM through the APM entity (if an APM entity does not report data on behalf of individuals or groups participating in the APM, those physicians will be required to report quality data on their own);**
  - **Report data for the Advancing Care Information category on their own; and**
  - **Automatically earn all the total available points for the Improvement Activities category score.**

  Similar to determining the thresholds for participation in Advanced APMs, **CMS will award the same final MIPS score to all the participants in a MIPS APM entity—including for data they reported individually or as a group under a single TIN**. Under the terms of the models considered MIPS APMs, participants in the APM entities are already assessed collectively for meeting certain quality and cost metrics; therefore, CMS **will score the Advancing Care Information and Improvement Activities categories collectively, as well.** CMS will use an average score of all the participants' scores for Advancing Care Information to determine a group score. All participants in the MIPS APM will receive the same total available score for Improvement Activities. The MIPS APM entity's final MIPS score will be applied to the participants in the entity at the TIN/NPI level.

- **What are patient relationship categories and modifiers—and how and when will I have to use them?**

  MACRA requires CMS to develop a series of categories to indicate the type and level of relationship physicians have with specific patients. CMS has released an updated proposal to require physicians to use modifiers on claims beginning in 2018 to indicate the type of relationship. The information will be used to attribute the costs of caring for individual patients to their physicians to determine Resource Use. CMS' updated proposal also includes several recommendations from ASCRS•ASOA and the medical community to simplify the categories and better reflect specialty practices. The new proposal includes categories for specialty chronic care and surgical care; however, there is no category that incorporates the two types of care. ASCRS recommended a category that incorporates both—to reflect ophthalmic practices—and will continue to recommend it in our comments on the updated proposal. A final policy is expected sometime in 2017.

- **What are episode groups and how will they affect my resource use score?**

  To better measure resource use and, in the future, be used for Medicare payment, MACRA requires CMS to develop episode groups (or groupers) based on specific episodes of care for certain procedures and chronic conditions. Current resource use measures are primary care-based, and so MACRA intended that the episode groups cover a wider array of physician services to impact a greater percentage of Medicare physician reimbursement, including specialty services. Since ophthalmology has a high volume of Medicare procedures, it is likely that several episode groups will be developed for ophthalmic procedures and conditions. There are several current proposals for episode groups, and additional groups are in development. While CMS did finalize a cataract episode group in the MACRA final rule, the Resource Use category will not be

included in physicians' MIPS final scores. In addition, the other proposed methods of creating episode measures, including several ophthalmic episodes, have not been finalized. CMS has provided physicians with Supplemental QRUR reports as an example of how their practice may fare under the model for cataract surgery included in the final rule, based on 2014 data. To access your Supplemental QRUR, log into the CMS Enterprise Portal. ASCRS and others in the ophthalmic community are providing input on the proposals not included in the final rule and recommending that the groups not be developed until more adequate risk adjustment models are developed. Further, we oppose attributing costs to physicians that are beyond their control. ASCRS is concerned that if the measures are not properly developed, physicians will be disincentivized against treating the sickest and riskiest patients. It is likely that the episode groups developed to measure resource use will eventually be used as the basis of bundled episode payments, which may qualify as advanced APMs in the future. ASCRS is monitoring the development of these episodes closely and will continue to provide input and advocate to ensure these measures do not unfairly penalize our members, or limit Medicare beneficiaries' access to specialty care.

- **If your practice administers influenza vaccines to its employees and reports that activity to a local immunization registry, does that qualify as fulfilling the immunization measure in the Advancing Care Information category?**

  If the administration of the immunizations is captured in their CEHRT and the practice submits immunization data to a public health agency electronically and receives immunization forecasts and histories from the public health immunization registry/immunization information system, then they would fulfill the immunization registry reporting measure.

- **How many bonus points are possible in the public health objective of the performance score in the Advancing Care Information category?**

  The immunization registry measure of the public health objective is worth 10% of the performance score for both 2014 and 2015 certified EHR technology (CEHRT) measures and objectives. There are no exclusions for specialties that do not perform immunizations, since only measures in the base score are required. The measure for the immunization registry is not in the base score, and thus is optional. Each type of registry is considered a different measure in the public health objective. There are 155 available points for the Advancing Care Information category, but the highest score a provider can earn for the category is 100. Possible bonus points in the public health objective depend on what type of EHR certification you have. If you have 2015, then there are four available registry measures within the public health objective beyond the immunization registry, each worth up to 5 points for a total of 20%. For 2014 CEHRT users, there are two available registry measures in the public health objective beyond the immunization registry, each worth up to 5 points for a total of 10%. Participants do not need to report the immunization registry measure to be eligible to receive bonus points for reporting to other types of registries. Providers with either 2015 or 2014 technology can earn an additional 15% in bonus points (5% for each registry) if they report to more than one of any of the registries included in the public health objective, including immunization registries. For example, if a provider reports to a local immunization registry and the IRIS registry (a clinical data registry) and then reports to an additional immunization registry and an additional clinical data registry, he or she would receive 10 percentage points for the first immunization registry, 5 percentage points for IRIS, and 5 percentage points each for the two additional registries.

- **Are physicians who meet the low-volume threshold included in the group score?**

  For MIPS eligible clinicians who report as a group, the low-volume threshold will be determined based on the group as a whole—in this case, the low-volume threshold would be determined based on considering the volume across all NPIs billing within that TIN, regardless of MIPS eligibility. Therefore, some NPIs within a TIN may be excluded from MIPS individual reporting requirements and payment adjustments. However, if the TIN chooses to participate in MIPS as a group, data for those NPIs would be included when determining the group's performance.

- **Why was Continuing Medical Education (CME) not included in the final list of improvement activities?**

  ASCRS•ASOA and others in the medical community recommended in our comments on the proposed rule to include CME as an improvement activity; however, CMS did not include CME in the final rule. CMS responded to the comment in the final rule, noting that it did not have a mechanism for evaluating CME. We are recommending in our comments on the final rule that CME from accredited organizations, such as ASCRS, should be included in future years, and CMS does not have the authority to evaluate CME.

- **Will the new Congress and administration repeal MACRA?**

  It is unlikely MACRA will be repealed since it passed with overwhelming bipartisan support, and efforts to tie physician payments to quality and value metrics are bipartisan. It is also important to remember that MACRA was not included in the Affordable Care Act (ACA), and any attempts to repeal the ACA will not impact MACRA. Despite this, ASCRS•ASOA will continue to advocate for changes to the MACRA policy to reduce the regulatory burden on our members and help them be successful in the program.

- **Do I still have to participate in PQRS, Meaningful Use and the Value-Based Payment Modifier?**

  MACRA consolidated these programs and sunset the penalties at the end of 2018. Therefore, physicians still had to participate in the programs through 2016 to avoid penalties for 2018. The MIPS program continues the existing two-year look-back, so the first year of MIPS reporting, 2017, impacts payments in 2019.

- **Do I need an EHR to participate in MIPS?**

  MIPS includes the Advancing Care Information Category (ACI), which requires the use of certified EHR technology. However, since MIPS scores are a weighted sum of all the categories, not completing one of the categories will not result in a total failure for the program. For the first year, (2017 reporting) ACI is weighted at 25% of the overall score. If you do not have an EHR, and do not complete ACI, your score will be no higher than a total of 75 points, but you still can make some points through the remaining categories. **Most importantly, for the first year, just reporting one quality measure on one patient, without having to meet the patient thresholds or measure benchmarks, will ensure you avoid a penalty entirely.** The quality measure may be reported via claims or registry, thereby eliminating the need to use an EHR for the first year.

- **How Do I Earn an "Exceptional Performance" Bonus?**

  If an individual or group's final MIPS score is 70 or above, that will qualify for an exceptional performance bonus. There are separate funds set aside for this bonus, and it is not subject to budget neutrality requirements. CMS will make this determination based on all the data submitted. However, physicians would need to fully participate in more than one performance category and the best way to ensure that their performance is high is by participating for a year (or as close to a year as possible). Ophthalmologists are well-positioned to reach this threshold, due to the availability of several outcome measures in the Quality category, additional bonuses for electronic reporting, and available improvement activities, to name a few. Since CMS has made it very easy to avoid a penalty for the first year of MIPS, there is likely not going to be much money collected from penalties to re-distribute as bonuses for providers who score above the threshold. Aiming for 70 points in the final MIPS score to achieve the exceptional performance bonus is the only way to guarantee a bonus in 2019.

- **Are there different reporting requirements in MIPS for small or solo practices?**

  Following advocacy from ASCRS and the medical community, CMS has made accommodations to help small practices succeed in MIPS. For the Quality and Improvement Activities categories, practices with 15 or fewer Medicare providers are subject to eased scoring requirements. In the Quality category, small practices must report on 6 quality measures, one of which must be an outcome measure or a high priority measure if no outcome measure is available, and will be scored out of a possible 60 points. For larger practices of 16 or more Medicare providers, CMS will also calculate an "all-cause hospital readmission measure" through Medicare claims, and score the category out of a possible 70 points. However, only practices that have 200 attributed patients will have the measure calculated and incorporated in the score. For the Improvement Activities category, ophthalmologists who practice in groups of 15 or fewer are only required to complete one high-weighted or two medium-weighted activities for full credit—40 points—for the category**.** For larger practices, high-weighted activities are worth 20 points, and medium-weighted activities are worth 10 points. Therefore, larger practices must complete a greater number of activities (in any combination of weights) to achieve full credit for the category.

- **Is the performance period 90 days, or 90 business days?**

  The 2017 performance period is any continuous 90 calendar days.

- **Do I have to report on just Medicare patients or all patients?**

  For the quality category, if you report via claims you are required to report on 50% of Part B patients. If you use EHR or registry reporting, you must report on ALL patients. For the Advancing Care Information category, you must report on all patients.

- **Do physicians who have opted out of Medicare need to participate in MIPS?**

  Physicians who have opted out of Medicare and are seeing Medicare patients through private contracting are not receiving payments from Medicare, and thus, do not have to participate in MIPS.

- **Are cross-cutting measures required in the Quality category?**

  No, CMS did not finalize its proposal to require a cross-cutting measure. Cross-cutting measures are still available to report if a physician or practice chooses, but are not required.

- **What data do I have to report for the Cost category?**

  No data submission is required for the Cost category. CMS will calculate the physician's or group's score through claims. It is important to remember that Cost will not be included in the first year's MIPS score, however, CMS will calculate the cost measures for information purposes.

- **Are the computerized physician order entry (CPOE) and clinical decision support (CDS) measures still required under Advancing Care Information and are scribes still required to be certified?**

  CMS eliminated these measures from the Advancing Care Information category, however, certified EHR technology must still have the capability to complete these functions. Therefore, if scribes are entering clinical data, they should still have the certification relevant to their individual duties.

- **Where do I find detailed information on the Improvement Activities, and what kind of documentation is required?**

  CMS has not released detailed specifications for the improvement activities but has indicated it will be releasing guidance on how to document the activities. In conversations ASCRS and the medical community have had with CMS regarding the lack of information related to improvement activities, CMS has indicated that documentation should be retained to reflect the improvement activity the practice is completing. For example, if the practice is choosing expanded practice hours, they should keep a record of materials that indicate the extended hours.

- **What are the Quality measure benchmarks?**

  Unlike under PQRS, in which providers simply had to report on certain measures to achieve an incentive or avoid a penalty, MIPS participants must now demonstrate improved quality above a baseline level. For the 2017 performance year, CMS has set a baseline performance benchmark for each measure based on 2015 performance data**.** Providers will be scored on performance in the first year, but must demonstrate improvement in later years. For 2017, each measure has specific benchmarks depending on submission method (i.e., claims, EHR, registry) that are scored on a decile, or ten point, scale. For each submission method, CMS has assigned different levels of performance to each decile. Each decile is a range of performance levels for the measure that correspond to points earned for the measure. For example, if a physician submits data showing 83% performance on a measure, and the 5th decile begins at 72% performance and the 6th decile begins at 85% performance, then he or she will receive between 5 and 5.9 points because 83% is in the 5th decile. The measures and benchmarks are available at http://www.ascrs.org/mipsquality .

- **If I report using the IRIS Registry, what measures and benchmarks do I use?**

  If you have full integration between your EHR and the IRIS registry, then you must report measures that are available for EHR reporting. The measures will be scored on the EHR benchmarks. If you do not have integration between IRIS and your EHR, and enter your data in manually, then you report on measures for registry reporting, and use registry benchmarks. The measures and benchmarks are available at http://www.ascrs.org/mipsquality .

Full information on how to participate in MIPS is available on the ASCRS' MACRA Center web page at ascrs.org/macracenter. If you have additional questions, please contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.