Frequently Asked Questions
MACRA, MIPS & APMs

Below are some frequently asked questions about the MACRA Quality Payment Program (QPP) MIPS/APM reporting for PA/LTC based clinicians. For a more comprehensive overview please visit the Society’s website http://www.paltc.org/macra as well as the official CMS QPP page https://qpp.cms.gov/.

Of special note, the Society hosted several webinars free for Society members on the topic. To view a recording with CME credit, please visit: http://www.paltc.org/product-store/role-qios-new-payment-models and http://www.paltc.org/product-store/archived-webinar-overview-macra-paltc-practitioners. The Society is hosting several presentations during the Annual Conference that will be recorded and available to view as well as planning future webinars on the topic.

Q: I practice exclusively in the nursing home setting; do I have to participate in MIPS?

A: Yes, for the 2017 reporting period, MACRA defines the following as eligible clinicians:

- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist

If you are billing any Medicare Part B E&M Code, including the SNF/NF CPT family of codes, you become an eligible clinician under the law.

Note—if you are a facility employed physician and do not bill Part B under your own NPI, you would not be eligible.

Q: Are there exclusions that would exempt my MIPS participation altogether?

A: Yes, there are several exclusions:

- Clinicians in their first year of Medicare Part B participation
- Clinicians billing Medicare Part B up to $30,000 in allowed charges or providing care for up to 100 Part B patients in one year
Clinicians in entities sufficiently participating in an Advanced APM, that meet specific requirements, for which either:

- The collective Part B payments for services delivered by the Advanced APM entity’s clinicians to patients attributed to the entity is at least 25% of the payments for services delivered by the entity’s clinicians to all patients who could, but may not, be attributable to the entity ("attribution-eligible")
- The collective number of patients who receive services delivered by the Advanced APM’s clinicians and who are attributed to the Advanced APM is at least 20% of the number of all patients who are attribution-eligible and received services delivered by the Advanced APM’s clinicians.

**Note**—there are no exemptions by place of service for SNF/NF patient encounters. Every patient for which an E&M code is submitted counts towards your MIPS score.

**Q: What are the Categories that make up the MIPS Score?**

- Quality (60% for 2017) – similar to old PQRS reporting
- Advancing Care Information (ACI, renamed from Meaningful Use) (25% for 2017)
- Improvement Activities (IA) (15% for 2017) – new category -https://qpp.cms.gov/measures/ia
- Cost (0% for 2017, but will be weighted for 2018 and beyond)

The performance category weights can be adjusted in certain circumstances. See FAQ on ACI as an example.

**Q: What are the quality measure requirements?**

**A:** For this category, ECs must report on at least 6 quality measures with at least one that is an outcome measure or a high priority measure. Overall, there are more than 300 measures and 51 measures that are reportable in the SNF/NF settings (meaning the denominator of the measures contains one of the CPT codes 99304-99318). The Society has recommended a set of measures to report on its website [http://www.paltc.org/public-policy](http://www.paltc.org/public-policy) (bottom of faq).

**Q: I have an ambulatory EHR and my facilities use different EHRs, is there a hardship exemption for me for the ACI Category?**

**A:** Yes, the CMS final rule specified that the Lack of Control over the Availability of CEHRT (as specified in 42 CFR 495.102(d)(4)(iv)(A)) will carry over into the ACI category. In such cases, the MIPS eligible clinician must have no control over the availability of CEHRT. CMS further specified that a majority (50 percent or more) of their outpatient encounters must occur in locations where they have no control over the health IT decisions of the facility. Control does not imply final decision making authority. CMS will issue guidance on how to apply for this hardship exemption at a later date. Note, if you apply and receive the hardship exemption, this category will be reweighed to 0 and the percentage applied to the Quality category making Quality worth 85% of your total score.
Q: What is the Improvement Activities Category?

A: CMS has provided a list of more than 90 activities that are divided into nine general categories, including expanding practice access, APM participation, care coordination, and others. ECs will have to attest that they completed up to four of these activities for 90 days. More information on how to select and attest to these activities is available on the CMS QPP website https://qpp.cms.gov/measures/ia. The Society will monitor member participation in this category and will provide recommendations in the near future.

Q: What is “Pick Your Pace”?

A: CMS has provided an opportunity in 2017 to transition into this system by simply submitting some data. This can be reporting on one measure, for one patient, one time (any measure available in SNF/NF); or one IA; or the base ACI measures. Just by doing that you will not be penalized. If you are ready to take a deeper dive but would not be ready until later in the year, you can participate for 90 days and potentially receive some bonus payment, although it may not be as high as those who participate for a full year.

Q: I don’t have an EHR in my ambulatory practice since I see patients in the nursing home and use their EHR, how do I report in MIPS?

A: CMS lists several approved registry vendors who will work with your practice and facility EHRs to report your data. The list is located here https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016QualifiedRegistries.pdf. There is typically a charge associated with these services. ECs also have the option of reporting through a Qualified Clinical Data Registry (QCDR) https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/qualified-clinical-data-registry-reporting.html. The Society currently does not have a QCDR but CMS has published a list of available QCDRs https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016QCDRPosting.pdf.

Q: I am in a group practice, can the group report for me?

A: Yes, group practices have the option to report via the Group Practice Reporting Option (GPRO). CMS defines a group practice as a single Taxpayer Identification Number (TIN) with two or more MIPS eligible clinicians, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN.

Group Reporting via CMS Web Interface (reporting option for groups of 25 or more)

The submission criteria for quality measures for group reporting via CMS web interface for the 12-month performance period is the following:

- Must report on all measures included in the CMS web interface
- Must report on the first 248 consecutively ranked and assigned Medicare beneficiaries in the sample for each measure for module
• If the sample of eligible assigned beneficiaries is less than 248, then the group must report on 100% of assigned beneficiaries.

• Any measure not reported will be considered zero performance for that measure in CMS’ scoring algorithm.

• In 2017, the group will be required to report on 15 measures, but the group score will be based on eleven measures. An all-cause hospital readmission measure was finalized for groups of 16 or more clinicians and with 200 attributed cases.

**Note**—for groups that practice exclusively in the nursing facility, only 2 measures are available for reporting via this option: falls screening and influenza immunization.

**Group Reporting via Non Web-Interface (claims, QCDR, Registry, EHR)**

• Report at least six measures including one outcome measure or one high priority measure.

• If fewer than six measures apply, the EC or group must report on each measure that is applicable.

• If a group reports on a specialty-specific measure set which may contain few than six measures, they must report on all available measures within the set.

• Alternatively, if the specialty-specific measure contains more than six measures, then the EC is required to report at least six measures with at least one outcome measure or a high-priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures).

In 2017, physicians using a registry, QCDR, or EHR Direct have to report on a measure successfully on 50% of the EC or groups patients across all payers. ECs or groups submitting via claims must report on 50% of Medicare Part B patients.

An all-cause hospital readmissions measure applies to groups of 16 or more physicians and with 200 attributed cases.

**Q: What is the financial impact of participation in MIPS?**

**A:** For CY2017 performance period, your total Medicare payments would go down 4% if you don’t participate at all. If you partially participate (see Pick Your Pace) you would not receive a penalty but would not be eligible for a bonus. If you fully participate you could get up to a 4% bonus on top of your total Medicare revenue. This program is budget neutral so the bonus depends on overall EC performance in this program. The penalties/bonuses go up in subsequent years.

2017 participation will impact 2019 Medicare payments.

**Q: What is the Advanced Payment Model option?**

**A:** In order to be completely excluded from MIPS participation, ECs will have to be enrolled in one of the following APMs, which are considered Advanced APMs under the regulation:

• Medicare Shared Savings Program (Tracks 2 and 3)
• Next Generation ACO Model
• Comprehensive End Stage Renal Disease Care
• Comprehensive Primary Care Plus
In order for you to be considered a Qualified Participant in one of these Advanced APMs, you must meet the two criteria listed below and be included on the APMs participation list:

- The collective Part B payments for services delivered by the Advanced APM entity’s clinicians to patients attributed to the entity is at least 25% of the payments for services delivered by the entity’s clinicians to all patients who could, but may not, be attributable to the entity (“attribution-eligible”)

- The collective number of patients who receive services delivered by the Advanced APM’s clinicians and who are attributed to the Advanced APM is at least 20% of the number of all patients who are attribution-eligible and received services delivered by the Advanced APM’s clinicians

*Advanced APM qualified participants receive a 5% lump sum bonus on top of their APM savings and are excluded from MIPS participation.*

**Q: Are there any Advanced APMs if I practice exclusively in the nursing home setting?**

**A:** No, the current models focus on primary care delivery outside of the institutional setting. However, other models such as the Bundled Payment for Care Initiative (BPCI) may become Advanced APMs in subsequent years.

**Q: What happens if I currently participate in BPCI or another non-Advanced APM?**

**A:** CMS defines non-Advanced APMs as payment models run by CMS that include:

- CMS Innovation Center Model (other than a Health Care Innovation Award)
- Medicare Shared Savings Program Accountable Care Organizations (MSSP/Track 1 ACOs)
- Demonstration under the Health Care Quality Demonstration Program
- Demonstration required by federal law

CMS also identified certain APMs, known as “MIPS APMs” that include MIPS EC as participants and hold EC accountable for the cost and quality of care provided to Medicare beneficiaries. EC that are participants in MIPS APMs receive an APM scoring standard based on the performance of EC in the MIPS APM. Most Advanced APMs are also MIPS APMs, so an EC participating in the Advanced APM does not meet the threshold to become a Qualifying APM participant, they are eligible to be scored using the MIPS APM scoring standard. In addition, the Medicare Shared Savings ACOs track 1 and track 2 are classified as MIPS APMs. Complete list is available at https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf