MACRA FAQs

FREQUENTLY ASKED QUESTIONS

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Q: Who qualifies for the Quality Payment Program?
***A*:** Providers — physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists — who bill Medicare more than $30,000 a year or provide care for at least 100 Medicare patients qualify for MACRA. For providers new to Medicare in 2017, participation is not required next year.

Q: When does the Quality Payment Program start?
***A*:** Providers who are ready to start collecting performance data can begin as early as Jan. 1, 2017. However, CMS is offering providers the option to start anytime between Jan. 1 and Oct. 2. No matter when providers begin collecting data, it is due to CMS by March 31, 2018. The data collected in the first performance year will determine payment adjustments beginning Jan. 1, 2019.

Q: What options are there for participation?
***A*:** The final rule includes two pathways for provider participation: the Merit-Based Incentive Payment System(MIPS), and the Advanced Alternative Payment Model(APM). The first pathway, MIPS, is designed for providers in traditional, fee-for-service Medicare. The second, Advanced APM, is designed for providers who are participating in specific value-based care models.

Q: What is MIPS and how has it changed from the proposed rule?
***A*:** MIPS rolls together and subsets three legacy CMS programs: Meaningful Use, the Physician Quality Reporting System and the Value-Based Payment Modifier. Physicians will earn payment adjustments based on performance in four categories linked to quality and value that will be similar to the previous programs. Payment adjustments in the first year will be neutral, positive or negative up to 4 percent. This will grow to 9 percent by 2022. Since CMS rolled out the proposed MACRA rule, it has settled on a gradual ramp up to full participation, allowing physicians to pick their pace between the following four options for data collection in 2017.

- No participation and an automatic 4-percent negative payment adjustment.
- Submission of a minimum amount of data – i.e. one quality measure- and a neutral payment adjustment.
- Submission of 90 days of data for a potential small positive payment adjustment or a neutral adjustment.
- Submission of a full year of data for the potential to earn a moderate positive payment adjustment.

Q: Who qualifies as an advanced APM?
***A*:** Participation in an advanced APM allows physicians to earn a 5 percent lump sum incentive payment each year from 2019 through 2024 and avoid MIPS reporting requirements and payment adjustments. The final rule firms up details on what programs will qualify as advanced APMs. First, to qualify, advanced APMs must meet three requirements: Use certified EHR technology, base payments on quality measures comparable to MIPS and require providers to bear more than nominal risk. Beyond that, advanced APMs must also be an approved model by CMS.

The final rule identifies the following as advanced APMs for 2017:

- Comprehensive ESDR Care Model (LDO and non-LDO two-sided risk arrangements)
- Comprehensive Primary Care Plus Model – ***Banner Network Colorado participates in this program*
- Medicare Shared Savings Program Tracks 2 and 3 – ***Banner Health Network and Banner Network Colorado participate in these programs*
- Next Generation ACO Model

CMS has also signalled it plans to create additional pathways for participating in the advanced APM track, including a new accountable care organization Track 1+ model, the Comprehensive Care for Joint Replacement and the Medicare Diabetes Prevention Program. CMS plans to add these programs in 2017 or 2018.

Q: How will small practices be able to participate?
***A*:** Reflecting feedback from providers, CMS made adjustments to the proposed rule to help small, independent practices participate. Those who fall below the requirements of at least $30,000 Medicare Part B charges or 100 Medicare patients are exempt from participating in 2017. CMS estimates this represents 32.5 percent of clinicians, but accounts for only 5 percent of Medicare spending. CMS is also offering an option for small practices and solo physicians to join together in virtual groups and submit combined MIPS data. The final rule also allots $20 million a year for five years for training and education of physicians in practices of 15 or fewer and those who work in underserved areas.

Q: How is the final rule more streamlined?
***A*:** CMS made specific policy changes in the final rule to create a more unified program. It highlighted five key changes that reflect this effort to streamline Medicare reforms: More flexible options in the first year, adjustment of the low-volume threshold for small practices, establishing the advanced APM as a standard to promote participation in value-based care models, simplifying "all-or-nothing" EHR requirements and establishing the medical home model to promote care coordination.

Q: Where can I learn more?
***A*:** Along with the release of the final rule, CMS rolled out a website for physicians that explains the program and helps identify what measures are most meaningful to their practice or specialty. The website is available at https://QPP.cms.gov. The agency also plans to answer questions about the Quality Payment Program by email and phone.

Q: How are people responding?
***A*:** The American Medical Association responded positively to the news. "Our initial review indicates that CMS has been responsive to many of the concerns raised by the AMA, and in the days ahead, the AMA will conduct a comprehensive review of the final rule to ensure that it promotes flexibility and innovation in the delivery of care to help meet the unique needs of all patients," AMA President Andrew W. Gurman, MD, said in an emailed statement. "With the flawed sustainable growth rate formula — and its annual threat of steep payment cuts — permanently eliminated, the new law gives many physicians the opportunity to be rewarded for the improvements they make to their practices and for delivering high-quality, high-value care to Medicare patients."

Medical Group Management Association President and CEO Hallee Fisher-Wright, MD, echoed AMA's statement, but with some disappointment about the lack of flexibility beyond the first year. "MGMA is pleased with the significant burden reduction for physician practices in the first year of the MIPS program and new alternative payment model options outlined in the final rule," Dr. Fisher-Wright said in an emailed statement. "It's disappointing that flexibility provided for quality reporting in 2017 largely disappears in 2018 and beyond. CMS missed an opportunity to close the two-year gap between the measurement and payment periods, which would facilitate improved patient care by providing actionable feedback to physicians and more timely incentives. The sheer magnitude of a 2,400-page regulation and its impact on physician practices can't be ignored."

Q: What's next?
***A*:** The final rule will be open for comment for the next 60 days. Comments can be submitted at https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html?redirect=/eRulemaking.
CMS plans to implement the law in an iterative process, and will continue to host listening and learning sessions.