MACRA FAQ

In the healthcare industry, things don't stay the same for long — including clinician reimbursements. Under the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA), clinicians must choose between two new pathways to receive Medicare payments: the Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (APMs).

However, even if you have some basic knowledge of MACRA and its two payment paths, you may still be unsure about some of the details of the programs. We collected some of the most common questions about MACRA and compiled the answers in this FAQ.

Who is eligible for MIPS? I've heard that MIPS is only applicable to primary care providers.

Any physician, physician assistant, nurse practitioner, clinical nurse specialist or certified registered nurse anesthetists who bills Medicare is eligible to participate in MIPS. There are many specialties included in that group, so it does not only apply to primary care providers.

What is the patient threshold for MIPS?

You are **not** eligible to participate in MIPS if you don't meet a certain patient volume threshold. If you bill $10,000 or less in Medicare **and** you care for 100 or less Medicare patients in one year, you are not eligible to participate in MIPS.

MACRA is only a proposed rule for now, and there's a fairly extended period of time before we expect final clarification. What can practices to do prepare while we wait for details from the government?

First, we recommend that you study the proposed rule. There are resources to help you interpret the rule available through Greenway Health, AMA, MGMA and many other organizations.

In addition, while you may not be able to anticipate every detail of the rule, there are a few themes throughout the rule that point to its overall intent: patient engagement, care coordination, and risk stratification/use of analytics to determine quality and cost thresholds for your patient population. As you prepare for MACRA, keep those themes in mind.

Ask yourself:

- What am I doing to enhance my organization's patient engagement strategy?
- What am I doing to implement a comprehensive care coordination infrastructure that targets high-risk patients?
- How do I think about analytics? How can I use data to identify high-risk patients and track them from a quality and outcomes perspective?

By focusing on these themes of practice transformation, you'll be much better prepared for when the details of MACRA are released.

What's the difference between alternative payment models (APMs) and Advanced APMs?

What makes an APM advanced is whether or not CMS determines that you're taking on more than nominal financial risk. To take on more than nominal financial risk, an organization has to be at risk of losing money in the program — for example, through shared losses.

There's a separate definition for medical homes. For a Medical Home to bear more than nominal financial risk, your quality incentive or per member per month incentives must be at risk. However, there's a caveat to that: Under the medical home definition, you'll have to go through CMS actuary analysis and list it on their innovation center to be truly qualified as advanced.

If you participate in an APM, you must still report through MIPS. If you qualify as an Advanced APM, however, you'll be able to participate in a separate path that doesn't require MIPS reporting and provides a different bonus structure.

Do I qualify to participate in an Advanced APM?

Under the proposed MACRA rule, the Centers for Medicare & Medicaid Services (CMS) defines an Advanced APM as a program that has cost and quality measures that are similar (but not identical) to MIPS and presents more than nominal financial risk.

However, to avoid MIPS, it's not enough to simply be a part of an Advanced APM — you must also be a qualifying participant, which depends on one of two elements: how much you're paid through the Advanced APM relative to your revenue or how many of your patients you see through the Advanced APM. Under MACRA, as the years progress, you must receive incrementally more payments or see more patients through the Advanced APM.

For more information on this track, watch the Greenway Health webinar on Advanced APMs.

What's the difference between bonuses for MIPS and Advanced APMs? The MIPS incentives (upwards of 12 percent) sound much more appealing than the Advanced APM bonus of 5 percent.

Under the Advanced APM track, the bonus is a lump sum of 5 percent. If you're in MIPS, the bonus is on a sliding scale; however, it's not guaranteed. You're stacked up against every other eligible clinician that is participating in MIPS. If you perform above the set threshold, you have the potential to receive the bonus. However, no one really knows where that benchmark is going to fall, because CMS hasn't provided any firm guidelines.

In addition, to receive the MIPS bonus, you must complete the reporting requirements. Under the Advanced APM track, you simply have to be part of an Advanced APM to receive the lump sum.

What are the measures you have to report on for MIPS?

There are four performance categories that make up your MIPS score.

The quality performance category will count for 50 percent of the total MIPS score. You will need to make, depending on your group size, either 80 to 90 points in that quality category in order to receive the full 50 percent credit. There are about 200 measure options to choose from, each worth a range of points — typically one to 20 points each.

You don't have to receive full credit in this category to receive credit for all of MIPS. However, be aware that the less points you earn here also will be less percentage to add to your overall MIPS score.

There's also the advancing care information category, which makes up 25 percent of the overall MIPS score. 100 points are required for this category.

The clinical practice improvement activities category is worth 15 percent of your overall MIPS score. Each activity is worth 10 points, but those that are considered high-value activities are worth 20. 50 points will get you full credit in this category.

Your score for the resource use or cost category will be auto-calculated based on your Medicare claims.

For more information, watch the Greenway Health webinar on MIPS.

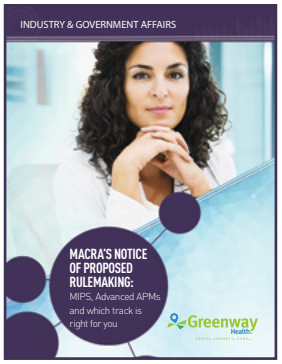
MACRA talks a lot about small practices. What defines a small practice, and how does MACRA plan to assist small practices?

In the proposed rule, a small practice is 15 providers or fewer. CMS realizes that it will be a little more challenging for small practices to meet MACRA, so they've provided some assistance — such as the low-volume threshold exclusion from MIPS. Also, small practices are only required to meet 80 points in the quality category of MIPS, rather than 90.

Does MACRA mean that meaningful use Stage 3 is going away?

As soon as MACRA goes into effect, Medicare meaningful use (MU) will no longer exist as a separate program. If the proposed rule timeline goes according to plan and 2017 is the first performance year for MIPS, then MU Stage 3 will go away. However, if the MACRA timeline is pushed back to 2018, for instance, then there will still be the option to report for MU Stage 3 in 2017.

The biggest takeaway here is that once MACRA begins, Medicare meaningful use, as a separate program, will end.



For a comprehensive overview of both payment tracks, download Greenway Health's guide, "MACRA's Notice of Proposed Rulemaking: MIPS, Advanced APMs and Which Track is Right for You."

If you still have questions about MACRA, visit the Greenway Health Knowledge Center for a wide variety of MACRA resources, including webinars, blogs, e-books and more.

Learn more...

To learn more about how Greenway Health can help with your transition to MACRA, call 877-537-0063.