



2017 MACRA FAQs

Created: Feb. 2017

The MGMA Government Affairs staff receive a variety of questions from medical group practice leaders on the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 and its two pathways, the Merit-Based Incentive Payment System (MIPS) and advanced alternative payment models (APMs). In 2017, CMS estimates that 90% of eligible clinicians will participate in MIPS so MGMA has compiled a list of the most commonly-asked MIPS questions submitted by your colleagues. We anticipate updating these FAQs regularly and encourage you to visit mgma.org/MACRA for the most up-to-date version of this document, as well as the latest information and MGMA resources on MIPS and APMs.

Search by topic:

- [General MIPS reporting](#)
- [Group reporting](#)
- [Clinicians who bill under multiple TINs or switch practices](#)
- [Quality measures](#)
- [Improvement Activities](#)
- [Advancing Care Information \(ACI\)](#)
- [MIPS exclusions](#)

General MIPS reporting

Q: Can I choose which 90 days of data to report? Does it have to be the same 90-day period for all of the performance categories?

A: Yes, practices may choose any window of time they would like to report up to a full year, as long as it is consecutive and a minimum of 90 days. For instance, a practice cannot report for 60 days in March and April, not report any data in May, then report again for 30 days in June to reach the full 90 days. Practices may choose different reporting periods for each of the performance categories.

Q: Do I get higher score for reporting for a longer period of time?

A: While practices are welcome to report data over longer intervals of time to improve their numerator for certain measures, there is no inherent benefit to a clinician's or practice's MIPS score for reporting data for longer than 90 days in 2017. In other words, if two practices both perform exactly the same on a particular measure and one reported for the full year while the other reported for 90 consecutive days, both would receive the same score.

Q: Can I report MIPS data through multiple reporting mechanisms?

A: Clinicians and groups may select a different reporting mechanism for each of the performance categories, but the Centers for Medicare & Medicaid Services (CMS) will generally only count data from one reporting mechanism per category. There is one exception for CAHPS for MIPS survey data, which counts as one quality measure and may be reported along with data from one additional reporting mechanism in order to satisfy complete reporting requirements for the quality performance category.

Q: How do I report for MIPS if I'm participating in an Accountable Care Organization (ACO)?

A: It depends on the type of ACO. Medicare Shared Savings Program (MSSP) Tracks 2 and 3 ACOs and Next Generation ACOs all qualify as Advanced APMs. Provided the ACO meets participation thresholds, clinicians participating in these ACOs are exempt from MIPS altogether. Track 1 MSSP ACOs must still participate in MIPS, but will be scored according to the "APM scoring standard," which differs from traditional MIPS in the following ways: 1) the MIPS score will be assessed at the ACO-level, not the TIN-level; 2) the performance categories will be weighted differently (quality will be worth 50%, ACI 30%, and improvement activities 20%); 3) MSSP ACOs will automatically earn full credit for the improvement activities category; and 4) quality data is submitted by the ACO, but ACI data is submitted by each TIN.

Group reporting

Q: My practice is still deciding whether to report for MIPS as a group. Is it too late to register?

A: Unlike in PQRS, MIPS has no mandatory registration process for group reporting, with the exception of groups electing to report CAHPS for MIPS survey measures or through the CMS Web Interface, both of which have a registration deadline of June 30 during the performance year. For groups that report via qualified clinical data registry (QCDR), qualified registry, or electronic health record (EHR), CMS will discern from the data submitted whether it represents group or individual submission. CMS instructs groups to work with vendors as necessary to ensure that when submitting data, it is clearly indicated that the data is intended to be evaluated at the group-level.

Q: For practices reporting quality data as a group via QCDR, qualified registry, or EHR, do all clinicians need to select the same six quality performance category measures, or can individual clinicians report different measures? What if a particular measure does not apply to all of the clinicians in my group?

A: For group-level reporting, all clinicians billing under the group tax identification number (TIN) need to report data for the same six quality measures. To satisfy data completeness requirements, the group must collectively report on at least 50% of all patients, regardless of payer, that meet a measure's denominator criteria. It is possible to meet this threshold as a group without every clinician contributing to measure requirements. If a group elects to report more than six quality measures, the highest scoring six will be counted.

Q: Are there different requirements for individual versus group reporting?

A: No. However, the level at which you report at may impact other factors, such as the submission mechanisms available to you and how clinicians are scored. For example, group-level reporters cannot report quality data for MIPS via claims. Groups would also have to agree on the same six measures and meet reporting thresholds collectively, plus their performance data would be aggregated across the TIN and analyzed and scored at that level.

Clinicians who bill under multiple TINs or switch practices

Q: How will MIPS scores and payment adjustments be determined for clinicians who switch practices or bill under multiple TINs during the same performance year?

A: When determining MIPS payment adjustments for a given payment year, CMS will look to see whether there is any historic performance data associated with a clinician's current TIN/NPI combination and will defer to that data over another TIN during the same performance period. For instance, if Dr. John Smith left practice A and started at practice B on July 1, 2017, his 2019 payment adjustment would be based only on data reported under practice B. Now let's say Dr. Smith left practice A in 2018 (so after the performance period). In this scenario, there would be no performance data for

him at practice B from 2017, so in this case CMS would use Dr. Smith's data from practice A to determine his MIPS score and would apply any resulting adjustment to his payments at practice B. In a third scenario, imagine once again that Dr. Smith has data under both practice A and practice B in 2017, and is now at an entirely new practice C in 2019. CMS would calculate separate MIPS scores for Dr. Smith under both practice A and practice B and would use the higher of the two to determine a payment adjustment that would be applied to his payments at practice C.

Q: Will a clinician's performance still impact a practice's MIPS score and resulting payment adjustment if he/she has since left the practice?

A: If the practice was reporting as a group for that performance period, then yes. All of the clinicians billing under that TIN would have had their performance data aggregated together to determine a single group score that would be applied to each of the TIN/NPI combinations for that performance period. Even if a particular NPI has since moved on from the practice, his/her data would have already been included. If, on the other hand, the clinicians reported individually during the performance period and a clinician has since left, his/her performance would in effect have no impact on the group, because MIPS scores "follow the NPI." Looking at it the other way, if a practice hires a clinician, his/her payments would continue to be adjusted based on his/her actual performance during the performance period, even if under a different TIN. The clinician would not simply adopt the new practice's payment adjustment during the payment year, even if that new practice participates in MIPS as a group.

Quality measures

Q: Can I report a quality measure if it only applies to a small number of patients?

A: Generally, quality measures must include at least 20 cases and meet applicable reporting thresholds (which vary by reporting mechanism) in order to be scored on a performance basis and eligible for the maximum ten points. Measures that were reported but did not meet reporting requirements will receive three points in the transition year (2017). Web Interface measures have different rules which require that each measure be reported on the first 248 consecutively-assigned or 100% of Medicare beneficiaries and measures that do not satisfy reporting requirements will receive a score of zero.

Q: Is it true that as a practice we only have to report one quality measure for one patient and we avoid a MIPS penalty? I don't see this stated anywhere in the final rule.

A: The one measure for one patient isn't stated outright in the rule. Rather, it is an interpretation of the three-point "floor" established for scoring quality measures in 2017. Reported quality measures will earn a score of at least three points, regardless of whether it meets data completeness requirements (excepting Web Interface measures). The MIPS performance threshold, i.e., the minimum score to avoid a MIPS penalty, is also set at three points this year. Therefore, reporting a quality measure through most reporting mechanisms, even just for one patient, will hit that threshold to avoid a MIPS penalty. Practices can also avoid a penalty by having one clinician attest to one improvement activity for any 90 consecutive days or by reporting the four ACI base measures. MGMA recommends practices report more than the minimum requirements as added protection against a penalty.

Q: What if a quality measure is designated by CMS as "topped out?"

A: In 2017 there will be no practical difference between "topped out" measures and other quality measures. However, practices should be aware that these measures are specifically targeted by CMS to be "potentially revisited" and may not be available in future reporting years.

Q: How will quality measures that don't have benchmarks be scored?

A: For quality measures that do not have an assigned benchmark based on historic data at the start of the performance period, CMS will use data from the performance period to create benchmarks. At the time of scoring, quality measures that do not have a benchmark either from historic or performance period data will be considered a "class 2 measure" and will automatically receive three points, excepting web interface measures. Web Interface users must report all 14 Web Interface measures, so if a measure sufficiently meets reporting requirements but does not have a benchmark, it will not be counted (so as to not adversely impact a practice's score).

Q: Is the CAHPS patient satisfaction survey still required for large practices under MIPS?

A: No. CAHPS for MIPS is optional for all practices reporting as a group. If a practice elects to submit CAHPS survey data, it would count as one high-weighted improvement activity and one quality measure. The group would have to report additional quality measures through another reporting mechanism to maximize their quality score. CAHPS for MIPS will be largely consistent with the CAHPS for PQRS survey in design. Interested groups must register by June 30 of the performance year.

Improvement Activities

Q: Some of the improvement activities are broadly-worded; for example, there is no timeframe on what constitutes "timely communication of test results." Is CMS going to release activity specifications or clarifying guidance on each activity?

A: CMS has indicated that it does **not** intend to release any more specific information further clarifying what would count or not count for each improvement activity. For 2017, practices should rely on the activity description in the improvement activity [inventory](#). CMS reminded MGMA members that the improvement activities category will feature a simple yes or no attestation and that activities were kept broad purposefully. The agency encourages practices to retain any supporting documentation.

Q: How many clinicians must participate in an improvement activity to achieve points for the entire group?

A: If at least one clinician within a group is performing the activity for a continuous 90-day period, the entire group may attest to completing the activity if reporting at the group level.

Q: Is it prohibited to attest to the same improvement activities for multiple performance years?

A: No. In 2017, as long as the activity is listed in the inventory in future performance periods, practices can continue to report the same activities, though CMS did indicate they may revisit this in the future. Additionally, practices can attest to completing activities that started prior to the performance period and are continuing, so long as the activity is being performed for at least 90 consecutive days during the performance period.

Q: With regard to the improvement activity that states "regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanisms," are we required to use the CAHPS for MIPS survey?

A: Given that there will be no additional specifications for 2017 and there is no specific assessment mechanism provided, practices can administer surveys per their own design for this medium-weighted activity. There is a separate, high-weighted activity for participating in the CAHPS survey or another "supplemental questionnaire." The CAHPS survey will also count as one quality measure (refer to the quality section of this FAQ for more information).

Advancing Care Information (ACI)

Q: Does MGMA have a standard or template security risk assessment for meeting this requirement of ACI? Does this measure require that the entire team complete the security risk assessment?

A: MGMA developed a HIPAA [Security Risk Analysis Toolkit](#) to assist members in both meeting ACI requirements and complying with HIPAA. There is no difference between the security risk analysis requirement under HIPAA, meaningful use, or the new ACI category under MIPS. For ACI in 2017, a security risk analysis is typically conducted for the entire organization, and therefore MIPS clinicians (if reporting individually) or the group practice (if reporting as a group) would simply attest "yes" to conducting the analysis to receive credit for this component of ACI.

Q: I see that reporting improvement activities via an EHR could earn me 10 bonus points toward my ACI score. Can I choose from any of the improvement activities?

A: Some, but not all of the improvement activities can earn bonus points toward the ACI category if reported through an EHR. The subset of activities that qualify can be found in Appendix B of this CMS [ACI fact sheet](#).

Q: Do I still need to get my medical assistants certified to meet the computerized provider order entry (CPOE) objective like we did in Meaningful Use?

A: No—CPOE is not required as an ACI objective under MIPS.

Q: I see health information exchange and provide patient access listed as both a base and performance measure. How will that work?

A: These two measures are mandatory as components of the ACI “base score,” which is worth half of the total ACI score. If clinicians or groups do not attest to completing these or any of the base score measures, they will receive an ACI score of zero. However, unlike the other two base measures, these will also be scored on a performance basis. In addition, these two performance measures are worth twice the amount of points as the other performance measures (20 instead of 10).

Q: I reported to a syndromic surveillance registry, which was required in Meaningful Use. Is this still required in ACI?

A: Only immunization registry reporting is a performance measure in MIPS. However, practices may earn 5 bonus points (each) for reporting data to a syndromic surveillance or specialized registry.

MIPS Exclusions

Q: How will the low-volume threshold be determined? How will I know if it applies to my clinicians?

A: The low volume exclusion is determined at the individual (TIN/NPI) level for clinicians reporting individually and at the group (TIN) level for practices reporting at the group-level, in which case all clinicians would either collectively exceed the low-volume threshold or they would not. Therefore, clinicians who fall below the threshold as an individual may find themselves required to participate in MIPS as part of a group. As a reminder, the low volume threshold excludes individual clinicians and groups from MIPS reporting requirements if they bill less than or equal to \$30,000 in allowed Medicare Part B charges or furnish care to 100 or fewer unique Part B patients during a determination period.

Q: Will CMS be notifying clinicians about whether they fall below the low-volume threshold or are considered a hospital-based or non-patient facing clinician?

A: Yes. CMS indicated in the final MIPS/APMs rule that it intended to send out notification letters prior to the start of the 2017 performance period; however, notices are still outstanding. The agency has more recently stated that it anticipates releasing at least low volume notifications in “late February or early March 2017.”

Q: How will MIPS payment adjustments affect rural health clinics (RHCs) and federally qualified health centers (FQHCs)?

A: Services paid under an all-inclusive methodology or prospective payment methodology at an RHC or FQHC are not subject to MIPS payment adjustments.

Q: Are non-physician practitioners (NPPs) required to report for all categories of MIPS? Will they be exempt from ACI, like they were Meaningful Use?

A: NPs, PAs, CRNAs, and CNSs are considered “eligible clinicians” required to participate in MIPS. However, participation in ACI is optional for non-physician eligible clinicians in 2017. If they do not submit data for ACI measures, they will have their ACI scores weighted to zero and that 25% weight allocated to the quality category.*

Q: Are hospital-based clinicians required to participate in MIPS?

A: Hospital-based clinicians are required to participate in MIPS; however, they are not required to submit data for the ACI performance category and will have their ACI score re-weighted to zero and that weight transferred to the quality category.* A hospital-based clinician is defined as a clinician who furnishes 75% or more of services at place of service (POS) codes 21, 22, or 23 during a prior determination period.

Q: Are pathologists or other specialists that lack face-to-face interaction with patients automatically excluded from MIPS?

A: Unlike in previous programs, CMS will not automatically exclude a provider based on their specialty designation in PECOS. However, there are flexible reporting options for clinicians or groups that are considered non-patient facing, defined as an individual clinician who bills 100 or fewer patient-facing [encounters](#) during a prior determination period or a group comprised of at least 75% of clinicians that meet this definition. Non-patient facing clinicians or groups may have their ACI score weighted to zero (and that 25% category weight transferred to quality)* and will receive automatic half credit in the improvement activities category.

***To learn more about MIPS exclusions and preferential scoring,
download MGMA’s member-benefit [resource](#).***

**If an NPP, hospital-based clinician, or non-patient facing clinician chooses to voluntarily report on ACI measures, they will be scored on the ACI performance category like all other MIPS clinicians.*