Are there any exclusions to the MACRA Quality Payment Program?
Yes, physicians and other providers who are new to Medicare or who are a Qualifying Participant (QP) in an Advanced Alternative Payment Model (APM) are exempt from reporting in the Merit-based Incentive Payment System (MIPS) track of the Quality Payment Program. For performance year 2018, individuals and groups are also exempt if they fall below the low-volume threshold. The threshold is seeing 200 or fewer Medicare patients or submitting $90,000 or less in Medicare Part B allowed charges. Low-volume and new Medicare providers have the option to participate in an Advanced APM, but do not have to.

If I am MIPS-exempt, will I have to participate in the Advanced APMs or is this optional? How will it affect me if I choose not to participate in the Advanced APMs when MIPS-exempt?
If you are exempt from MIPS, you do not need to participate in an Advanced APM. If you choose not to participate in an Advanced APM and are exempt from MIPS, you will receive payment based on the Medicare Physician Fee Schedule. In 2019, there will be a 0.5 percent increase to the schedule. From 2020 to 2025, there will be no increase.

What steps should we take if we know that we are exempt based on the low-volume threshold to avoid possible penalties for non-reporting?
If you are determined to be exempt based on the low-volume threshold, you will not face any penalties for not reporting in MIPS.
I will be exempt. If I choose not to report, what impact will this have in the future on other payers, such as TRICARE, Medicaid, and commercial plans?

If you are exempt, then you do not have to report; you do not have to make a choice.

Other payers may adopt some of the aspects of the Quality Payment Program, such as similar quality or cost measures, but it is unlikely that the Quality Payment Program nor MIPS will be adopted in whole by another program or private payer. However, you may need to make comparable investments related to quality reporting and more efficient use of resources in order to move toward value-based payments to be successful with other payers.

Additionally, beginning in performance year 2019, APM Entities and individual eligible clinicians will be able to gain QP status through participation in a combination on Medicare Advanced APMs and other-payer Advanced APMs. Other-payer arrangements must require at least 50% of participants to use certified electronic health record (EHR) technology, include quality measures comparable to those in MIPS, and exceed specified thresholds of risk. Eligible clinicians who are partial QPs for the year under the All-Payer Combination Option can elect whether to report in MIPS.

To be exempt under the low-volume threshold, do you have to meet both criteria for exemption or just one of them?

You only have to meet one of the criteria: seeing 200 or fewer Medicare patients or submitting $90,000 or less in Medicare Part B allowed charges. For example, if you see 250 Medicare patients and submit $85,000 in Medicare charges, you would be exempt. Additionally, if you see 180 Medicare patients and submit $140,000 in Medicare charges, you would also be exempt. Please note that the low-volume threshold is determined at both the individual and group level; while you might meet the low-volume threshold as an individual, if your group elects to report together under the practice’s Tax Identification Number (TIN), the threshold may be exceeded when all of the participating providers are aggregated together.

What if I have more than 200 Medicare patients, but less than $90,000 in Medicare Part B charges?

You will be exempt from MIPS.

I only see a couple of Medicare patients per month so I never did Meaningful Use (MU) and I am getting a 2 percent deduction already. Will I continue to be penalized?

MU payment adjustments sunset in 2018. MU has been adapted and integrated into the MIPS Advancing Care Information performance category. If you are not exempt from MIPS, you may receive a zero for your Advancing Care Information score if you do not have an EHR or do not report on the required measures in this category. The measures for 2018 are based primarily on Stages 2 and 3 of MU. If you are exempt from MIPS, you will not be penalized beginning in 2019.

If a physician decides to no longer take Medicare patients, does s/he have to continue seeing existing patients with Medicare?

No. If you elect non-participation (non-PAR) or decide to be a private contracting physician, you do not
have to see or accept any Medicare patients. You should notify your patients that you are no longer a participating Medicare physician and whether you are non-PAR or a contracting physician.

**Will the Quality Payment Program result in even fewer providers caring for Medicare patients?**

It is possible that some physicians may opt out of Medicare to avoid the investments needed to comply with the Quality Payment Program or to avoid the negative payment adjustments. Medicare is an optional program for physicians. Physicians should consider the volume of Medicare patients that they see when determining whether or not to participate in Medicare. Physicians may also want to take into account that other government payers, such as Medicaid, and commercial plans may adopt aspects of the Quality Payment Program in future years, like quality reporting or cost measurement, so opting out of Medicare may not relieve physicians from these requirements.

If you want to change your status for next year, you will need to do so by December 31. If you do not participate with Medicare or privately contract with Medicare patients, you cannot participate with Medicare Advantage (MA) plans.

For more information on your Medicare participation options, you can review the American Medical Association’s [toolkit](#). ACOG is not advising or recommending any of the options detailed in the American Medical Association’s toolkit.

**Does the MACRA Quality Payment Program replace the Physician Quality Reporting System (PQRS) and the Medicare EHR Incentive Program, also known as Meaningful Use (MU)?**

Yes, PQRS and MU, along with the Value-based Payment Modifier (VM), are now part of MIPS. MIPS is one of the tracks that makes up the Quality Payment Program. Payment adjustments for PQRS, VM, and MU will sunset in 2018 based on performance in 2016. MIPS payment adjustments will begin in 2019 based on performance in 2017.

**Is the Centers for Medicare and Medicaid Services (CMS) still moving forward with the changes to Medicare?**

Yes, the MACRA Quality Payment Program is being implemented in accordance with the requirements laid out in the final rule. MACRA was passed with overwhelming bipartisan support in both houses of Congress and does not face the same political issues that the Affordable Care Act (ACA) does. The Quality Payment Program will be subject to annual rulemaking and there will likely be changes made to the requirements for future performance and payment periods based on the feedback received from the physician community and other stakeholders.

**We are a large group. How do our ob-gyns separate?**

The entire group would have to un-assign their billing rights to the TIN, not just the ob-gyns if you are in a multi-specialty practice. You should consult your legal counsel regarding how to do this and whether there may be ramifications related to other contracts or agreements to which your group is a party.

**When looking to see if my practice sees less than 200 Medicare patients, is secondary Medicare also included?**
The low-volume threshold determination is applied to traditional Medicare Part B beneficiaries only. Secondary Medicare patients are not applicable for the low-volume threshold determination.

How does Medicare evaluate differences in resource use that are influenced by regional variation in costs in MIPS?

CMS uses a payment standardization methodology that excludes the Medicare geographic practice cost index (GPCI) and the hospital wage index for cost measures. CMS previously used this methodology in the VM and will continue to use it in the Cost Performance Category in MIPS.

Standardization removes price differences that a physician cannot control through the delivery of efficient care. As CMS noted in the final rule to the CY 2013 Medicare Physician Fee Schedule, “[t]he per capita cost measures themselves will show regional differences in Medicare spending, but the standardization process ensures that differences in cost measures do not reflect differences in Medicare’s price indices such as the GPCI.” ([77 FR 69317](https://www.gpo.gov/fdsys/pkg/FR-2012-01-20/pdf/2012-07348.pdf))

How will hospitalists be affected in MIPS?

The Advancing Care Information performance category gets reweighted to zero so hospital-based clinicians do not have to report any of those measures. The weight for that category will be redistributed to the Quality performance category, so quality will be 85 percent of the score and improvement activities will be 15 percent.

A hospital-based clinician is defined “MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the Place of Service (POS) codes 21, 22, and 23 used in the HIPAA standard transaction as an inpatient hospital, on campus outpatient hospital or emergency room setting in the year preceding the performance period.” CMS may make adjustments to how hospital-based physicians are scored in future years.

Can general gynecologists participate in the American Urogynecologic Society’s (AUGS) registry?

The AUGS Urogynecology Quality Registry (AQUIRE), traditionally only available to AUGS members, can now be used by non-members. For more information, visit AUGS’ [webpage](https://augs.org).