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 (A-APM) are exempt from reporting in the Merit-based Incentive Payment System (MIPS) track of the Quality Payment Program. For performance year 2019, individuals and groups are also exempt if they fall below the low-volume threshold. The threshold is seeing 200 or fewer Medicare patients, submitting $90,000 or less in Medicare Part B allowed charges for covered professional services, or providing 200 or fewer Part B covered professional services. Low-volume and new Medicare providers have the option to participate in an A-APM, but are not required to do so.

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 are not required to participate in an A-APM. If you choose not to participate in an A-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 under 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 are not required 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 or 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 of 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 all three criteria for exemption or just one of them?

You only have to meet one of the criteria: seeing 200 or fewer Medicare patients, submitting $90,000 or less in Medicare Part B allowed charges for covered professional services, or providing 200 or fewer Part B covered professional services. For example, if you see 250 Medicare patients, submit $85,000 in Medicare charges for covered professional services, and provide 180 covered professional services, you would be exempt. Additionally, if you see 180 Medicare patients, submit $140,000 in Medicare charges, and provide 150 covered professional services 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.

Can I choose to participate in MIPS even though I am exempt under the low-volume threshold?

Beginning in 2019, clinicians or groups that meet or exceed one or two of the low-volume threshold criteria can choose to opt into MIPS. For example, if you provide more than 200 Part B-covered professional services, but do not have 200 Medicare patients or at least $90,000 in allowed charges for Part B covered professional services, you can opt in to participation. Individuals and groups that opt in will be treated as MIPS-eligible clinicians, meaning their performance will be scored and they will receive a payment adjustment based on that score. To opt in, you must affirmatively elect to participate on the Quality Payment Program website. Individual and groups that are considering opting into MIPS should carefully compare the benefit of a modest positive payment adjustment to the cost of collecting and reporting data.

Physicians or groups who do not meet or exceed any of the low-volume threshold criteria cannot opt in and are automatically exempt. Physicians who meet or exceed all three criteria are required to participate.
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 or the CMS website. ACOG is not advising or recommending any of the options detailed in the American Medical Association’s toolkit. Physicians must evaluate options and decide what is best for their practice.

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 ended in 2018. MIPS payment adjustments began in January 2019 based on performance in 2017.

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 Medicare as secondary insurance also included?
The low-volume threshold determination is applied to traditional Medicare Part B beneficiaries only. Patients with Medicare as their secondary insurance 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)

How will hospitalists be affected in MIPS?

A hospital-based clinician is defined as a “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.”

The MIPS Promoting Interoperability performance category gets reweighted to zero for all hospital-based clinicians, so hospitalists 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 70 percent of the total MIPS score, improvement activities will be 15 percent, and cost will be 15 percent.

Beginning in 2019, hospital-based clinicians can apply scores from the Hospital Value-Based Purchasing (VBP) Program to their MIPS score for the Quality and Cost performance categories. CMS will apply the higher score to clinicians’ Cost and Quality categories, whether it is the Hospital VBP score, or data submitted by the clinicians themselves. If the hospital that the clinician is attributed to does not receive a Total Performance Score for a given performance year in the Hospital VBP Program, then the hospital-based clinician would have to report to MIPS via another method.

Are there any specialty specific Improvement Activities that ob-gyns can complete for the Improvement Activities performance category?

Beginning in 2019, ob-gyns can receive credit for one Improvement Activity if they complete the Safety Certification in Outpatient Practice Excellence for Women’s Health (SCOPE) and also receive Maintenance of Certification Part IV credit for completion. For more information, visit the SCOPE webpage. Ob-gyns who complete SCOPE will also have to complete 2-3 more Improvement Activities to receive full credit for this performance category.

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.
I have additional questions about the MACRA Quality Payment Program. Where can I get them answered?

You can submit additional questions to ACOG’s Practice Management Ticket Database, and our staff will work to answer them. For more detailed information, visit the Quality Payment Program website. You can also contact CMS by email at QPP@cms.hhs.gov or by phone at 1-866-288-8292/ TTY: 1-877-715-6222.