



Frequently asked questions about MACRA

Contents

What is MACRA?.....	2
Who will be affected by MACRA?.....	2
Why does this matter?	2
What is the Merit-based Incentive Payment System (MIPS)?	2
What does MIPS mean for you and your team?	3
What are Advanced APMs?	3
What is the path forward for IRs and APMs?	4
How does being categorized “patient-facing” or “non-patient facing” change my MACRA experience? Should IRs strive for one over the other?	4
What is the difference between individual and group reporting?.....	5
How are hospital-employed and multispecialty practice physicians treated under MACRA?.....	5
What can IRs do to succeed under the MACRA Quality Payment Program?.....	6
What is the IR Registry? How will participation help me thrive under MACRA?	6
What are standardized reports? How will they help me meet my MACRA requirements?	7
How are standardized reports generated?	7
Do you have additional questions about MACRA?	7

What is MACRA?

In April 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) became law, substantially changing how Medicare payments will be made to all physicians, including interventional radiologists and diagnostic radiologists. MACRA mandated that Medicare payments be based on quality and created a new [Quality Payment Program](#) with two payment paths for providers—the Merit-based Incentive Payment System (MIPS) and the advanced Alternative Payment Models (APMs).

The Centers for Medicare and Medicaid Services (CMS) published its final rule on MACRA implementation on Oct. 14, 2016. This nearly 2,400-page document lays out a complex blueprint for implementation beginning Jan. 1, 2017, the first observation period under the new Quality Payment Program affecting payments in 2019. The final rule reflects many of the SIR recommended changes, most notably a “pick your pace” option for 2017 that offers flexible participation options tailored to varying levels of preparedness.

Who will be affected by MACRA?

All physicians, physician assistants, nurse practitioners, clinical nurse specialists and nurse anesthetists. Starting Jan. 1, 2017, all affected providers will be able to choose amongst four options that will be used to determine their payments under the new Quality Payment Program in 2019. CMS will expand the list of eligible providers in 2019.

Why does this matter?

The Sustainable Growth Rate (SGR) model for physician payment is eliminated and replaced with a system that rewards value and quality—the [Quality Payment Program](#). The Quality Payment Program is based on quality measurements for care that you and your team provide to patients and are different from current incentive programs, such as the Physician Quality Reporting System (PQRS). Physicians will be paid via one of two Quality Payment Program methods: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

By tying payments to outcomes and quality of care, MACRA and the Quality Payment Program will require interventional radiologists to demonstrate strong quality and resource use scores based on the measures outlined below.

What is the Merit-based Incentive Payment System (MIPS)?

MIPS is a new payment model option that provides physicians with financial incentives *and penalties* based on quality, outcomes and efficiency. MIPS consolidates the existing quality reporting systems—the Physician Quality Reporting System (PQRS), the Value-based Modifier Program, and the Medicare Electronic Health Record (EHR) Incentive Program—into one scoring system. On the basis of the recently released final rule, MIPS will attribute provider performance across four categories:

- **Quality** (60 percent of total score in year 1): Providers choose six measures to report to qualified registries from a pool of CMS-defined, specialty-specific options.

- **Advancing care information/EHR meaningful use** (25 percent of total score in year 1): You would choose “customizable measures” that reflect your day-to-day use of technology to manage and share patient information. CMS will place emphasis on “interoperability and information exchange,” with the goal of having a patient’s health records available across all systems to allow any provider needing to care for that patient to have open access to their medical history. CMS says that “unlike the existing reporting program, this category would not require all-or-nothing EHR measurement or redundant quality reporting.”
- **Clinical practice improvement activities** (15 percent of total score in year 1): Physicians will be rewarded for “clinical practice improvements, such as activities focused on care coordination, beneficiary engagement and patient safety.”
- **Cost/resource use** (0 percent weighting of total score in year 1): Cost will not be weighted in the first performance year but providers will still receive feedback on performance. A physician’s score will be based on Medicare claims, using “40 episode-specific measures to account for differences among specialties.”

These four categories will be weighted accordingly and all *individual* providers will be given their own composite score from 0–100, which will then be used to determine their reimbursement rate. Providers falling within the mean will see a flat adjustment rate; while providers falling above or below the threshold will see their rates go up or down, accordingly. Composite scores will be displayed on CMS’ Physician Compare website. CMS anticipates that most providers will participate in MIPS in the early years of MACRA implementation.

What does MIPS mean for you and your team?

In September, CMS offered flexibility in MACRA participation by creating a “pick-your-pace” track for the 2017 participation year. This allows providers to choose from four pathways to ease into the program gradually or embrace it wholeheartedly. At the gradual end of the spectrum, a provider can choose to submit data on a single measure and be held harmless from a negative update. At the intermediate levels of participation, they can participate in the full MIPS program for either 90 days or the full year. These two paths offer increasingly higher positive financial incentives. And at the fullest degree of participation, a provider can be fully engaged in an Advanced Alternative Payment Model, although CMS expects only a minority of providers to be ready for this option in 2017. To see how your payment may be affected, [view a timeline from CMS here](#).

Remember, this is more than just payment adjustments, penalties and rewards. Accountability and scoring will be applied across a multispecialty team and team players will be chosen accordingly. In future years, a physician’s quality and cost rankings will be publicly available on the national federal website, [Physician Compare](#).

What are Advanced APMs?

MACRA has built on incentives that seek to transform care and delivery by rewarding the adoption of APMs, such as accountable care organizations (ACOs), bundled payment models, patient-centered medical homes and other shared savings programs where clinicians accept both risk and reward for providing coordinated, high-quality and efficient care. Thus, while most

providers are expected to adopt MIPS at first, the other way MACRA will provide payment incentives is through advanced APMs. Specifically, physicians who “participate to a sufficient extent” in APMs that meet criteria for payment based on quality (advanced APMs) would be exempt from MIPS reporting requirements and qualify for a lump-sum incentive bonus. However, participants would also have a greater downside risk. To qualify for APM-based reimbursement, a certain percentage of Medicare payments must be from APMs, as follows:

- In 2019 and 2020, at least 25 percent of Medicare payments attributable to services provided through a qualifying APM.
- In 2021 and 2022, at least 50 percent of Medicare payments attributable to services provided through a qualifying APM, or at least 50 percent of payments from all payers and 25 percent of Medicare payments attributable to services provided through a qualifying APM.
- In 2023 and beyond, at least 75 percent of Medicare payments Medicare payments attributable to services provided through a qualifying APM, or at least 75 percent of payments from all payers and 25 percent of Medicare payments attributable to services provided through a qualifying APM.
- Starting in 2026, APMs will offer some participating health care providers higher annual fee schedule updates.

CMS believes many physicians will not initially be able to meet some of MACRA’s APM requirements for sufficient participation, so the proposed rule provides financial rewards within MIPS and the ability to switch between the components of the Quality Payment Program as the program matures. CMS is aiming to have 85 percent of U.S. health care expenditures processed through APMs by 2022.

What is the path forward for IRs and APMs?

CMS has focused on primary care rather than specialty care for their work to date on APMs, as many primary care APMs are already quite advanced. Going forward, when primary care physicians refer patients to specialists, they will be looking closely at cost, quality and outcomes before making that referral. IRs must be able to prove they can compete across all specialties in terms of efficacy and resource utilization, even if it is not yet clear how IR-based APMs will be designed. The greatest challenge for IR as it relates to APMs is the diverse number of specialties with which we interact. This broad diversity makes the APM benchmarks set by CMS challenging in certain instances.

How does being categorized “patient-facing” or “non-patient facing” change my MACRA experience? Should IRs strive for one over the other?

SIR considers the practice of interventional radiology a “patient-facing” vocation and anticipates that most interventional radiologists will be considered “patient-facing” clinicians and thus will fully report on all MIPS measures.

However, under the rule, physicians who fall below pre-defined thresholds comprised of total billed Medicare charges, total Medicare patients seen, and/or a volume of 100 patient-facing procedures (specific “patient-facing” CPT codes have not yet been released) will either be excluded from MIPS or required to report on fewer MIPS measures. These “non-patient facing”

physicians may not have to report as much information as “patient-facing” physicians, but they also may not be eligible for the same level of bonuses as those fully reporting on all MIPS measures. Overall, SIR believes that the relative burden between patient-facing and non-patient facing is quite small and thus favors pursuing a patient-facing reporting strategy.

What is the difference between individual and group reporting?

Under MACRA, physicians have the option of reporting as a group or as an individual.

CMS proposes to use a combination of TIN/NPI as the identifier to assess the performance of an individual MIPS-eligible clinician. Each unique TIN/NPI combination would be considered a different MIPS-eligible clinician and MIPS performance would be assessed separately for each TIN under which an individual bills.

For a MIPS-eligible clinician who wishes to have performance assessed as part of a group, CMS proposes to use the group’s billing TIN. CMS proposes to codify the definition of a “group” as a single TIN with two or more MIPS-eligible clinicians (as identified by their individual NPIs) who have reassigned their billing rights to the TIN.

The statute allows for the use of voluntary “virtual groups” for certain assessment purposes, whereby a clinician, or group consisting of no more than 10 MIPS-eligible clinicians, could elect to form a virtual group with at least one other such individual MIPS-eligible clinician for a performance period. Because of technical and logistical barriers, CMS believes that this option is infeasible for the first performance period and plans to implement virtual groups for the 2018 calendar year performance period.

MACRA requires CMS, in specifying measures and activities for a performance category, to give consideration to the circumstances of professional types who typically furnish services that do not involve face-to-face interaction with a patient. The law also allows CMS to reweight MIPS performance categories if there are not sufficient measures and activities applicable and available to each type of MIPS-eligible clinician. CMS defines a “non-patient-facing MIPS-eligible clinician” as a MIPS-eligible clinician or group that bills 100 or fewer patient-facing encounters during a performance period. However, CMS has yet to release which codes are defined as “patient-facing.”

How are hospital-employed and multispecialty practice physicians treated under MACRA?

While specific employment models remain a challenging area of interpretation in the final rule, it is believed that hospital-employed physicians and members of multispecialty practices will be allowed to participate in MIPS under the TIN of their employer/health care system. In doing so, it appears that the hospital/health care system would be rated in the aggregate by only six quality measures. While this may seem to give a pass to many specialties who can “ride the coattails” of other specialties that are reporting, SIR firmly believes in the importance of IRs participating in the reporting process. It is entirely plausible that specialties that do not report will have very little bargaining power to claim potential QPP bonuses. Further, the absence of reporting precludes the tangible demonstration of value, potentially making IR completely expendable to the parent organization due to lack of participation in the QPP; and the absence of registry participation (the easiest and recommended way to report, see below) precludes

accumulation of clinical data in support of the IR value proposition and forms the basis of negotiations with payers and health care systems for MIPS and APM participation. There is no penalty for participation—CMS chooses the “best six” measures for composite scoring and bonus calculation, making maximal participation the best strategy. Failure to report means that other specialty measures will be used to represent IR, which in turn will reflect one’s practice inaccurately on public sites such as Physician Compare. If IR is to remain the first choice of patients, IR must prove its value and effectiveness through this reporting.

What can IRs do to succeed under the MACRA Quality Payment Program?

- **Participate in the IR Registry.** Members should contact practice managers now and discuss the steps you need to take to participate in this registry. ACR’s participation agreement should be part of this discussion and is available for download [here](#).
- **Become familiar with standardized reporting.** To optimize ease of use and minimize administrative burden on practicing IRs, registry participation is seamlessly carried out through use of standardized reports, which transparently/seamlessly send data to the registry. Many of those reports are available to download [here](#), with more on the way.
- **Learn more about quality through SIR’s Quality Toolkit.** Spend time with SIR’s Quality Toolkit, available [here](#), to learn what you need to know and do.
- **Stay tuned to SIR for ongoing updates.** SIR will keep members updated on the progress of MACRA and the IR Registry through regular updates in SIR’s *Guidewire* newsletter, the [Vision to Heal](#) blog, webinars, in-person meetings and more. For real-time updates please visit SIR’s “[MACRA Matters](#)” page.

What is the IR Registry? How will participation help me thrive under MACRA?

The new [IR Registry](#), which SIR developed in conjunction with the American College of Radiology, is a qualified clinical data registry (QCDR) that fits into the National Radiology Data Registry (NRDR) portfolio and will enable individuals or groups to take advantage of automated reporting of performance measures to CMS for those quality metrics in the IR standardized procedure reports. [A participation agreement is required to take part in the registry.](#)

This is important because participating in a QCDR aligned with the practice scope of interventional radiology would increase the number of available measures interventional radiologists could submit for PQRS and MIPS credit. Participation in a QCDR is an accepted mechanism that meets three of the four components of the MIPS composite score: quality measures, clinical practice improvement activities and advancing care information.

The participation agreement linked above details the cost of participation, how HIPAA is addressed and system requirements among other participation requirements. Please read it carefully when considering participation.

What are standardized reports? How will they help me meet my MACRA requirements?

To help IRs report into the new registry, SIR and SIR Foundation have created standardized reports that allow information-rich standardized procedures and post procedure IR reports for quality improvement and clinical research efforts. Thoughtfully designed standardized reports can power registries more effectively and efficiently than other time-consuming, web-based alternatives. Due to standardization of language and format, standardized reports are readily machine-readable. The data can be made anonymous and collected in an automated or semi-automated fashion into databases via automated connection between the registry and existing voice-recognition software. Continual aggregation of objective data from private and academic settings will be vital for evaluation of patient outcomes, comparative effectiveness studies, post-market device surveillance to support reimbursement. Based on lessons learned from a pilot study of standardized IR reports across the country, the next generation of reports is being developed for widespread dissemination to practices in the United States and abroad. All [currently available standardized reports are here](#) and additional standardized reports will be uploaded as they become available.

How are standardized reports generated?

Standardized reports are developed for IR procedures by Standardized Reporting Committee volunteers working with the Performance and Quality Improvement Committee. The general template was determined through working with interventional radiologists across practice settings and verified through a pilot study which included a survey to referring physicians regarding the structure and content of the reports. Additional reports are built onto this format, integrating performance measures as appropriate into the report text. Data extraction from standardized reports occurs at each practice's site and anonymized data is sent to the IR Registry.

The standardized reports' data collection process uses standardized report codes embedded in HL7 messages created by dictation systems. To collect data through this mechanism requires the use of standardized reports. This strategy enables the automated collection of performance measures as part of the routine clinical workflow. The reports' only mandatory fields are those which are used to extract performance measures. Although a clinical practice could opt to only use some of the standardized reports for their ongoing clinical work, the more consistent use of the standardized reports will expand provider options for reporting performance measures in the new Merit-based Incentive Payment System.

Do you have additional questions about MACRA?

Email them to SIR Director of Health Policy and Economics Robert White at rwhite@sirweb.org.