CIO CHEAT SHEET ON MACRA FINAL RULE

October 24, 2016

I. Background

On October 14, the Centers for Medicare and Medicaid Services (CMS) published a final rule with comment outlining the two new pathways stemming from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for physicians and other eligible clinicians beginning in 2017. MACRA repeals the Medicare Sustainable Growth Rate (SGR) methodology for updates to the Physician Fee Schedule (PFS) and replaces it with a new approach to payment called the Quality Payment Program (QPP) that rewards the delivery of high-quality patient care. There are two ways to participate in the QPP detailed below. Physicians and other eligible clinicians will have a choice of participating in the Medicare-based Incentive Program (MIPS) or the Advanced Alternate Payment Model (APM) track. Most physicians are initially expected to participate in MIPS. These two pathways are intended to move the nation closer to reimbursement based upon performance and value.

The rule also finalizes the requirements pursuant to MACRA around data blocking which apply to both physicians and hospitals, and the requirements calling for providers to attest on data blocking and support of surveillance of certified electronic health records (CEHRT).

II. Supporting Performance of CEHRT and Data Blocking

A. Attestation for Supporting Performance of CEHRT

MIPS eligible clinicians, as well as EPs, eligible hospitals, and critical access hospitals (CAHs) under the existing Medicare and Medicaid EHR Incentive Programs will be required to demonstrate cooperation with certain provisions concerning blocking the sharing of information pursuant to MACRA and, separately, to demonstrate engagement with activities that support health care providers with the performance of their CEHRT such as cooperation with the Office of the National Coordinator (ONC) with their direct review of certified health information technologies. In final rule published the same day as the MACRA final rule, ONC published a final rule outlining their plans for expanded oversight of CEHRT to ensure products are able to meet the criteria for which they have been certified. Until now, oversight was limited to reviews conducted by ONC-Authorized Certification Bodies (ONC-ACBs). ONC's direct oversight will focus on patient safety issues. A fact detailing more information can be found here.

In the MACRA final rule CMS created a two-part attestation process to ensure providers are supporting ONC's efforts. First, providers will be required to attest that they cooperated with ONC's direct review activities by: (1) attesting their acknowledgment of the requirement to cooperate in good faith with ONC direct review of their health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received; and (2) if a request is received, attesting that they cooperated in good faith in ONC direct review of health IT under the ONC Health IT Certification Program to the extent that such technology meets (or can be used to meet) the definition of certified EHR technology.

CMS also made it optional for health care providers to choose whether they want to attest that they engaged in good faith in helping support health care providers with the performance activities related to ONC-ACB surveillance (as opposed to ONC direct oversight efforts).

B. Data Blocking

CMS finalized what they called for in the proposed rule which calls on Meaningful Use, MIPS and APM participants to attest to the following three statements.

Statement 1: A health care provider must attest that it did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.

Statement 2: A health care provider must attest that it implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times: (1) connected in accordance with applicable law; (2) compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170; (3) implemented in a manner that allowed for timely access by patients to their electronic health information (including the ability to view, download, and transmit this information); and (4) implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated health care providers, and with disparate certified EHR technology and vendors.

Statement 3: A health care provider must attest that it responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor.

CMS clarified it is their expectation that, "a health care provider will not be held accountable for factors that it cannot reasonably influence or control, including the actions of EHR vendors."

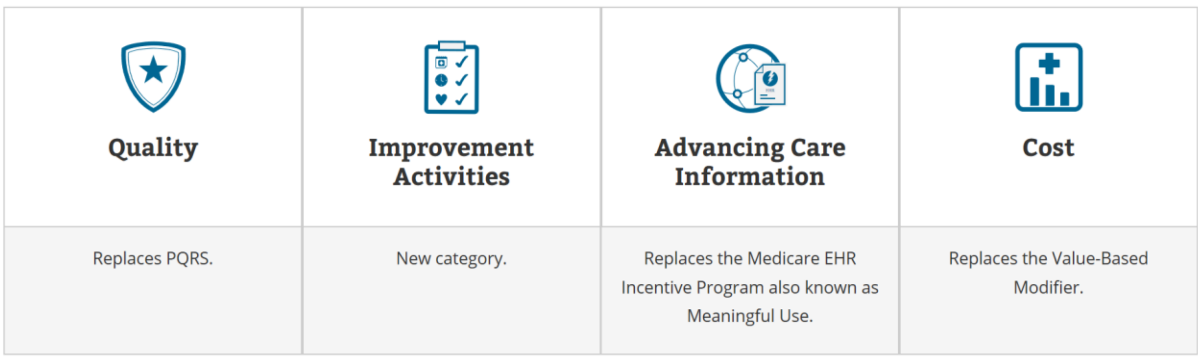
III. **Quality Payment Program:** Consists of two pathways for participation.

The Quality Payment Program has two tracks you can choose from:

Advanced Alternative Payment Models (APMs)		The Merit-based Incentive Payment System (MIPS)
If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.	or	If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

A. MIPS

Pursuant to MACRA, MIPS consolidates three reporting programs into one. The Meaningful Use, Physician Quality Reporting System (PQRS), and the Value-based Modifier (VBM) programs all sunset for physicians and other eligible clinicians. MACRA does not change reporting requirements or payment for hospitals or Medicaid providers. There are four performance areas that comprise MIPS. Each are weighed differently and contain their own sets of requirements. Clinicians will receive a final score based on a scale of 0 to 100 depicting how well they performed under the QPP. The score will aggregate their performance under the four performance categories. The more points a physician / clinician accumulates, the more incentive they stand to make.

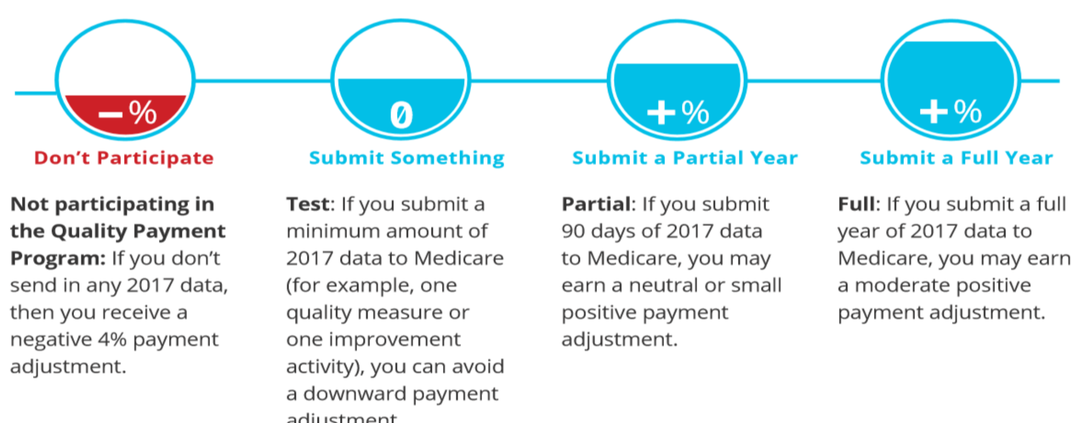


Quality	Improvement Activities	Advancing Care Information	Cost
Replaces PQRS.	New category.	Replaces the Medicare EHR Incentive Program also known as Meaningful Use.	Replaces the Value-Based Modifier.

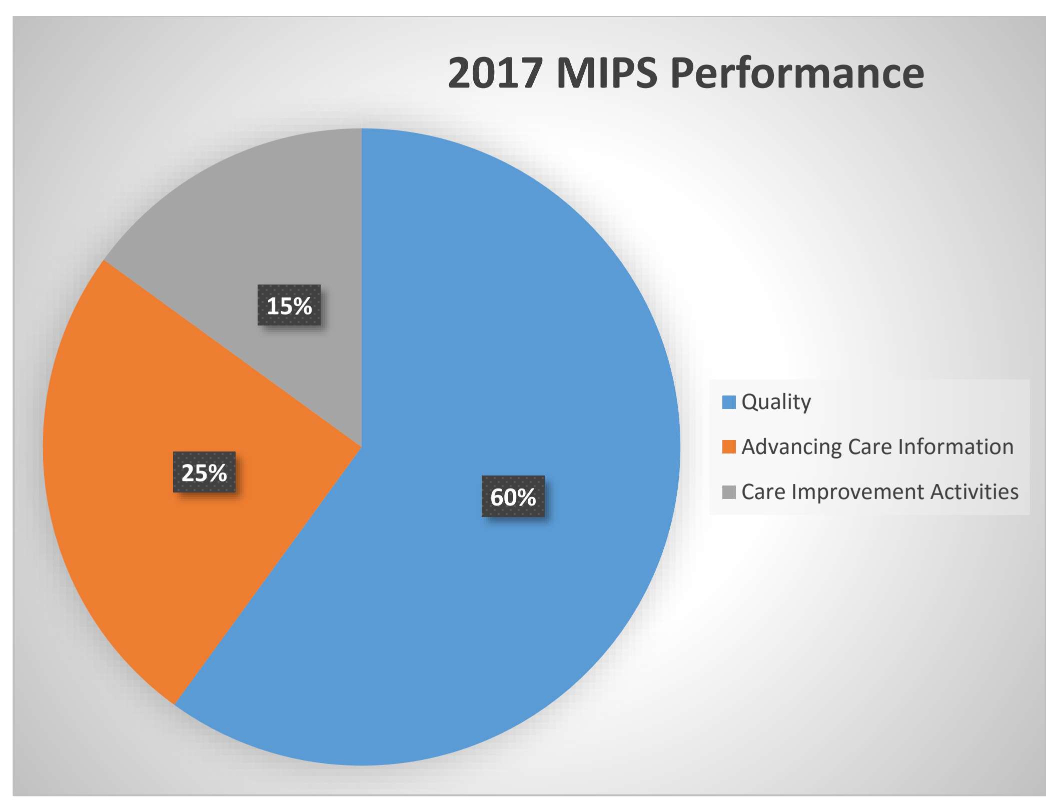
2017 as Transition Year: The requirements to meet MIPS during 2017 are lower than what will be required in future years as CMS views this year as a year of transition.

Eligibility: CMS estimates 500,000 clinicians will be eligible to participate in MIPS in 2017. Clinicians are eligible to participate in the MIPS track of the Quality Payment Program if they bill more than $30,000 to Medicare, and provide care to more than 100 Medicare patients per year, and you are a: physician, physician assistant, nurse practitioner, clinical nurse specialist, or a certified nurse anesthetist. Those participating in Medicare for the first time in 2017 are not required to participate in the QPP.

Payment Participation Options for 2017: Depending on how a clinician chooses to participate in MIPS and how much if any data they submit they will receive an incentive payment, no payment, or a cut to your Medicare reimbursement. CMS calls this the “pick your pace” approach.



Category Weights: The four categories are weighed as depicted below (the cost performance category is not included as it is weighted at zero for 2017).



Performance Category Details:

Performance Category	Final Weight for 2017	Measures for 2017
Quality	60%	• Points • 6 measures for most including an outcome measure for at least 90 days • 15 measures for groups using web-based reporting option • Certain APM participants meet quality reporting via their APM participation

Advancing Care Information (ACI)	25%	• Total possible points: 155 (anything over 100 means meeting full 25% of ACI score)
		• 40 points for “Base” score and 90 points max for “Performance” score
		• Base score:
		  o Meet for minimum of 90 days
		  o Must meet risk assessment; failure means zero for entire ACI category
		  o Report for at least patient the following:
		    ▪ eprescribing;
		    ▪ provide patient access;
		    ▪ send summary of care (SoC); and
		    ▪ request / accept SoC
		• Performance score: Choose up to 9 measures for at least 90 days
		• Extra credit:
		  o 5% bonus points for reporting one or more additional public health and clinical data registries beyond immunization
		  o 10% for reporting improvement activities using CEHRT

Improvement Activities	15%	• Attest to completing 4 activities for at least 90 days • Can choose from medium (10 points each) or high weighted (20 points each) activities or a combo of both • Groups with less than 15 participants, those in rural or health professional shortage areas (HPSAs), and non-patient facing clinicians only need to meet 2 medium or one high activity • Patient-centered medical home and certain others automatically get full 15% credit. Others can get half credit
Cost	0%	Not being counted for 2017. Will start to count in 2018.

Performance Period: Reporting for 2017 will affect 2019 payment. The performance period for 2017 is s minimum of 90 days for all performance categories with some limited exceptions. Data submitted for the quality performance category that is reported through the CMS Web Interface, for the CAHPS for MIPS survey, and administrative claims-based measures (including the all-cause hospital readmission measure) have a 12-month period from January 1 through December 3, 2017.

Data Submission: There are a variety of reporting mechanisms permitted by CMS. Clinicians may use different reporting mechanisms, however, they must use the same reporting mechanism within a single performance category. There are no data submission requirements for the cost performance category and certain quality measures (automatically calculated based on claims submissions). Also, the time during which data is allowed to be submitted is January 1 through December 21, 2017 (claims must be submitted no later than 60 days after the end of the performance period). And, data submission must be for 90 continuous days though clinicians may report longer than 90 days if they choose, which CMS encourages but does not require.

	Data Reporting Mechanism	
Category	**Individual Reporting**	**Group Reporting**
Quality	• Claims • QCDR • Qualified registry • EHR	• QCDR • Qualified registry • EHR • CMS Web Interface (groups of 25 or more) • CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism.) • Administrative claims (For all-cause hospital readmission measure - no submission required)
Cost	Administrative claims (no submission required)	Administrative claims (no submission required)
ACI	• Attestation • QCDR • Qualified registry • EHR	• Attestation • Qualified registry • EHR • CMS Web Interface (groups of 25 or more)
Improvement Activities	• Attestation • QCDR • Qualified registry • EHR	Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more)

Last day to report for 90 days: October 2, 2017.

Non-patient Facing Clinicians: Clinicians who are "non-patient facing," for the purposes of MIPS, are considered to be those who bill 100 or fewer patient-facing encounters (including telehealth) during the non-patient facing determination period. Groups are considered non-patient facing if more than 75 percent of the group's billing is made up of clinicians who meet the individual definition of non-patient facing.

Individual vs. Group Reporting: CMS allows for either. Whichever is used the clinician must use across all performance categories. And, clinicians will be identified based upon an NPI / TIN combination.

B. Advanced APMs

In the final rule CMS expanded the number of APMs that will be considered advanced APMs and announced they are exploring creating a new Track 1 ACO that will qualify starting in 2018 with lower downside risk.

Advanced APMs are a subset of APMs and let practices earn more for taking on some risk related to patients' outcomes. Participants can earn a 5% Medicare incentive payment during 2019 through 2024 and be exempt from MIPS reporting requirements (and possible cuts to Medicare reimbursement) if they meet certain requirements.

Requirements for Qualifying as an Advanced APM:

- Be CMS Innovation Center models, Shared Savings Program tracks, or certain federal demonstration programs
- Require participants to use certified EHR technology (CEHRT)
- Base payments for services on quality measures comparable to those in MIPS
- Be a Medical Home Model expanded under Innovation Center authority or require participants to bear more than nominal financial risk for losses. The final rule with comment period defined the risk requirement for an Advanced APM to be in terms of either total Medicare expenditures or participating organizations' Medicare revenue (which may vary significantly). This enhanced flexibility allows for the creation of more Advanced APMs tailored to physicians and other clinicians, such as advanced practice nurses, generally, and small practice participation in particular.

Criteria for Qualifying for 5% APM Incentive Payment: A participant must receive a certain percentage of their payments for covered professional services OR see a certain percentage of patients through their Advanced APM during the performance year. CMS estimates between 70,000- 120,000 clinicians will initially qualify for the 5% bonus. Details are below.

Table 1: Requirements for APM Incentive Payments for Participation in Advanced APMs
(Clinicians must meet payment or patient requirements)

Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Medicare Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Medicare Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

More ways for to participate in Advanced APMs: CMS expanded in the final rule the pathways for participating in an Advanced APM. For 2017 the following APMs qualify as Advanced APMs:

- Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)
- Comprehensive Primary Care Plus (CPC+)

- Medicare Shared Savings Program Track 2
- Medicare Shared Savings Program Track 3
- Next Generation ACO Model
- NOTE: CMS indicated that this list could change and they will publish a final one before January 1, 2017. The current list with details of which APMs are and are not Advanced APMs can be found here.

Future years: For 2018, in addition to the above list, CMS plans on possibly adding a ACO Track 1, New Voluntary Bundled Payment Model, and Advancing Cardiac Care Coordination through Episode Payment Models (cardiac and joint). While CMS plans on only including Medicare ACOs as Advanced ACOs at the start of the program, they plan on allowing participants in “Other Payer Advanced APMs” to participate and get credit in the future.

IV. Where to go for More Information

- CMS QPP website
- CMS QPP Fact Sheet
- CMS executive summary of the final rule
- CMS Final Rule with Comment (double-sided version)
- CMS blog on final rule

V. List of Tables in the Final Rule

Table Number	Description	Page Number
1	Proposed Data Submission Mechanisms for MIPS Eligible Clinicians Reporting Individually as TIN/NPI	288
2	Proposed Data Submission Mechanisms for Groups	288
3	Data Submission Mechanisms for MIPS Eligible Clinicians Reporting Individually as TIN/NPI	313
4	Data Submission Mechanisms for Groups	313
5	Summary of Final Quality Data Submission Criteria for MIPS Payment Year 2019 via Part B Claims, QCDR, Qualified Registry, EHR, CMS Web Interface, and CAHPS for MIPS Survey Performance	427
6	Proposed MSPB Reliability with TIN/NPI Attribution	590
7	Episode-Based Measures Finalized for the CY 2017 Performance Period	601
8	Improvement Activities Eligible for the Advancing Care Information Performance Category Bonus	707
9	Advancing Care Information Performance Category Scoring Methodology Advancing Care Information Objectives and Measures	768
10	Advancing Care Information Performance Category Scoring Methodology for 2017 Advancing Care Information Transition--Objectives and Measures 2017	770
11	APM scoring standard for the Shared Savings Program – 2017 Performance Period for the 2019 Payment Adjustment	895

12	APM scoring standard for the Next Generation ACO Model – 2017 Performance Period for the 2019 Payment Adjustment	908
13	APMs scoring standard for MIPS APMs other than the Shared Savings Program and Next Generation ACO Model – 2017 Performance Period for the 2019 Payment Adjustment	924
14	APM Entity Submission Method for Each MIPS Performance Category	927
15	Performance Category Performance Standards for the 2017 Performance Period	939
16	Example of Using Benchmarks for a Single Measure to Assign Points With a Floor of 3 Points	969
17	Quality Performance Category: Scoring Measures Based on Performance for Performance Period 2017	994
18	Examples Illustrating How End-to-End Electronic Reporting Requirements Work	1028
19	Quality Performance Category Example with High Priority and CEHRT Bonus Points	1036
20	Quality Performance Category Bonus Cap Example	1038
21	Finalized Quality Measures Available for MIPS Web Interface Reporting in 2017	1041
22	Example of Using Shared Saving Program Benchmarks* for a Single Measure to Assign Points with a Global Floor of 3 Points	1045
23	Comparison of Scoring Approach of Web Interface and Non-Web Interface Measures	1046
24	Scoring Examples: Groups Reporting via Web Interface with the Readmission Measure	1048
25	Example of Using Benchmarks for One Sample Measure to Assign Points1	1060
26	Finalized Improvement Activities Assigned the Highest Points	1070
27	Improvement Activities Performance Category Scoring Example 1	1090
28	Improvement Activities Performance Category Scoring Example 2	1091
29	Final Weights by Performance Category	1101
30	Performance Category Redistribution Policies for the Transition Year (MIPS payment year 2019)	1124
31	Illustration of Point System and Associated Adjustments in Transition Year	1169
32	QP Payment Amount Thresholds – Medicare Option	1506
33	QP Payment Amount Thresholds – All-Payer Combination Option All	1506
34	QP Patient Count Thresholds – Medicare Option	1506
35	QP Patient Count Thresholds – All-Payer Combination Option	1507
36	QP Payment Amount Thresholds – All-Payer Combination Option	1586
37	QP Patient Count Thresholds – All-Payer Combination Option	
38	All-Payer Combination Option Example 1	1639
39	All-Payer Combination Option Example 2	1641
40	All-Payer Combination Option Example 3	1644
41	All-Payer Combination Option Example 4	1645
42	Adjusted Hourly Wages Used in Burden Estimates	1752
43	Clinicians or Organizations Submitting MIPS Data On Behalf of Clinicians, by Type of Data and Category of Clinician	1731
44	Burden Estimate for Quality Performance Category: Clinicians Using the Claims Submission Mechanism	1741

45	Burden Estimate for Quality Performance Category: Clinicians (Participating Individually or as Part of a Group) Using the Qualified Registry/QCDR Submission	1743
46	Burden Estimate for Quality Performance Category Clinicians (Submitting Individually or as Part of a Group) Using the EHR Submission Mechanism	1747
47	Burden Estimate for Quality Performance Category Group Submission via the CMS Web Interface	1751
48	Burden Estimate for QCDR and Registry Self-Nomination	1754
49	Total Estimated Burden for MIPS Data Validation Survey	1755
50	Burden Estimate for Beneficiary Participation in CAHPS for MIPS Survey	1757
51	Estimated Numbers of Organizations Submitting Advancing Care Information Performance Category Data on Behalf of Eligible Clinicians	1758
52	Total Estimated Burden for Advancing Care Information Performance Category Data Submission	1760
53	Estimated Numbers of Organizations Submitting Improvement Activities Performance Category Data on Behalf of Eligible Clinicians Category	1763
54	Total Estimated Burden for Improvement Activities Submission	1764
55	Total Estimated Burden for Partial QP Election	1766
56	Proposed Annual Recordkeeping and Reporting Requirements	1768
57	Projected Number of Clinicians Ineligible For or Excluded From MIPS in CY 2017, By Reason	1781
58	MIPS Exclusions By Reason And Specialty For Mips Transition Year	1783
59	Total Exclusions By Reason And Practice Size For Mips Transition Year	1786
60	MIPS Estimated Payment Year 2019 Impact On Total Allowed Charges By Specialty, Standard Participation Assumption	1791
61	MIPS Estimated Payment Year 2019 Impact On Total Allowed Charges By Specialty, Alternative Participation Assumptions	1794
62	MIP Estimated Payment Year 2019 Impact On Total Allowed Charges By Practice Size, Standard Participation Assumptions	1797
63	MIPS Estimated Payment Year 2019 Impact On Total Allowed Charges By Practice Size, Alternate Participation Assumptions	1798
64	Accounting Statement	1814

VI. Appendices in Final Rule

Letter	**Description**	**Page Number**
A	Finalized Individual Quality Measures Available for MIPS Reporting in 2017	1902
B	Quality Measures That Are Calculated for 2017 MIPS Performance That Do Not Require Data Submission	2018
C	Individual Quality Cross-Cutting Measures for the MIPS to Be Available to Meet the Reporting Criteria Via Claims, Registry, and EHR Beginning in 2017" has been removed per policy change	2019
D	Finalized New Measures for MIPS Reporting in 2017 Title Basal Cell Carcinoma (BCC)/Squamous Cell Carcinoma: Biopsy Reporting Time – Pathologist	2019

E	2017 Finalized MIPS Specialty Measure Sets	2028
F	2016 PQRS Measures Finalized for Removal for MIPS Reporting in 2017	2114
G	Measures Finalized with Substantive Changes for MIPS Reporting in 2017	2126
H	Finalized Improvement Activities Inventory	2157