

November 2016

Making Sense of the MACRA Final Rule – Part 3 of 3: Merit Based Payment Incentive System (MIPS)

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The Centers for Medicare & Medicaid Services (CMS) recently released its final rule with comment period implementing the bipartisan *Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)*.

Among its numerous changes, MACRA replaced the Medicare sustainable growth rate (SGR) formula with a new system that links Medicare fee for service (FFS) payments for physician and other clinicians’ services to care delivery, quality and value-based variables.

This article is part of a three-part series that examines various legal, operational and strategic details and considerations related to MACRA based on the unpublished version of the final rule submitted to the Office of Management and Budget on Oct. 14, 2016. The final rule was published in the Federal Register on Nov. 4, 2016.

Specifically, this article examines the Merit Based Payment Incentive System (MIPS) under MACRA and the overall Quality Payment Program (QPP) being implemented by CMS via the final rule.

Separate articles in this series examine:

- Essential elements of the QPP, including its policy objectives, alternative participation vehicles, and key operational choices (MACRA Essential Elements), and
- MACRA’s Alternative Payment Model (APM) participation vehicle.



Recap on MACRA Basics and Objectives

Under MACRA, clinicians are required to participate in the evolving value-based payment system in ways that impact their Medicare FFS payments. Clinicians have a choice of vehicles in which to participate in the QPP and influence what they receive under Medicare Part B:

1. Participating in certain APM programs, such as the Medicare Shared Savings Program (MSSP), and others, or
2. Attesting to certain measures focused on clinical quality, technology and new care delivery approaches under MIPS.

The initial performance year for MIPS is 2017, with a MIPS eligible clinician’s performance during that year defining whether the clinician or his/her group receives positive or negative payment adjustments during the 2019 payment year. MACRA also provides an additional \$500 million for payment to “exceptional performers” under MIPS during the initial years of the QPP through 2024.

The MIPS performance and payment years are as follows:

Table 1: Payment Adjustments & Correspondent Performance and Payment Years

Performance Year	Payment Year	MIPS Positive or Negative FFS Payment Adjustment (plus possible additional exceptional performance (EP) incentive)
2017	2019	up to +/- 4% (plus possible EP incentive)
2018	2020	up to +/- 5% (plus possible EP incentive)
2019	2021	up to +/- 7% (plus possible EP incentive)
2020	2022	up to +/- 9% (plus possible EP incentive)
2021	2023	up to +/- 9% (plus possible EP incentive)
2022 and later years	2024 and later years	up to +/- 9% (plus possible EP incentive in 2024 only)

By law, and with limited exceptions, MIPS will be implemented on a budget neutral basis – creating financial winners and losers. CMS projects that approximately \$199 million dollars will be equally distributed for positive and negative MIPS adjustments, with those participants receiving a negative adjustment funding the positive payment adjustments, which are, therefore, capped to preserve budget neutrality.

From a policy perspective, MACRA and the QPP seek to:

- Require rapid migration from straight FFS to a largely “pay-for-value” payment system as consistent with CMS’ stated goal of linking 90 percent of Medicare FFS payments to quality or value by the end of 2018;
- Encourage migration to “Advanced APM” models; and
- Establish MIPS as a means of making FFS payments subject to measures directed at quality, innovation and value.

2017 as “Pick Your Pace” Transition Year

In response to stakeholder concerns about the short deadline to participate in the QPP starting in 2017, CMS reconfigured the final rule to establish 2017 as a transition year. Notably, rather than requiring eligible clinicians to gather information for the measures for the entire calendar year, the final rule gives them the option of gathering this information over a continuous 90-day period at any time during the 2017 calendar year. Further, during 2017, eligible clinicians may “pick [their] pace” for MIPS participation in 2017 by choosing one of the participation options listed in Table 2:

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Table 2: 2017 MIPS Participation Strategy & Corresponding 2019 Payment Implications

2017 Participation Strategy	MIPS Payment Implications for 2019
Report all required MIPS measures for a full 90-day performance period and up to the full year	Avoid up to the maximum -4% MIPS payment adjustment, qualify to receive up to the maximum +4% payment adjustment, with possibility to qualify for additional "exceptional performance" adjustment
Report MIPS for a full 90-day period (but less than a full year) and report more than one quality measure, more than one improvement activity, or more than the required measures in the ACI performance category	Avoid up to the maximum -4% MIPS payment adjustment and become eligible to receive up to the maximum +4% adjustment
Report one measure in each of the quality and improvement performance categories, or report the required measures of the ACI performance category	Avoid up to the maximum -4% MIPS payment adjustment (but not eligible for +4% adjustment)
Fail to report one MIPS measure or activity	Subject to maximum -4% MIPS payment adjustment in 2019

Practical and Operational Concerns -- Developing a MIPS Game Plan

The complex MACRA law and final rule include many highly technical details, so a game plan is essential for success.

To start, most clinicians will be subject to MIPS in 2017, given the finite pool of qualifying APMs that generally required participation back in mid to late summer 2016.

As a next step, clinicians should consider whether they are eligible for or exempt from MIPS participation. Note, even those clinicians who will participate in an APM in 2017 are

also "MIPS eligible clinicians" – meaning that despite their engagement with an APM, they may still be subject to MIPS.

MIPS Eligible Clinicians

Clinicians who bill under the Medicare Physician Fee Schedule (MPFS) and meet the definition of an "eligible clinician" must participate in an APM or MIPS. CMS finalized the definition of MIPS eligible clinicians, as originally proposed, to include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and a group that includes such clinicians. CMS will expand the definition by future rulemaking to include additional eligible clinicians.

In the final rule, however, CMS recognized exclusions for certain classes of clinicians, who otherwise would be "eligible clinicians":

1. New Medicare-enrolled eligible clinicians - Clinicians who first become a Medicare-enrolled eligible clinician during a defined performance year (e.g., 2017), and who have not previously submitted claims under Medicare either as an individual an entity, or as part of a physician group or under a different billing number or TIN.
2. Low-volume threshold clinicians - Clinicians who have a low Medicare volume either by (a) having \$30,000 or less in billed Medicare Part B allowed charges; or (b) 100 or fewer patient-facing Part B-enrolled beneficiary encounters, including telehealth services.
3. Qualifying APM Participants (QPs) or Partial Qualifying APM Participants (Partial QPs) – Clinicians who

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participate in an APM that meets certain additional criteria during the applicable performance period.

Additional details regarding these types of excluded clinicians are found in the other articles in this series which specifically address the MACRA Essential Elements and APMs.

Performance Years and Payment Years

The performance year for MIPS is the calendar year two years prior to the year in which the MIPS payment adjustment is applied – meaning the 2017 performance period defines the MIPS adjustment in 2019, and so on, as reflected in Table 1 of this article. During each applicable performance year, data is reported and measured against standards established by CMS. That performance is then used to calculate a composite score (referred to herein as MIPS score or final score), which is used to determine the payment adjustment for the time period occurring two years later (the applicable payment year).

Under the final rule, no later than 30 days prior to January 1 of the applicable payment year, CMS will determine the MIPS payment adjustment (including any exceptional performance adjustment) that will apply to claims submitted by each MIPS eligible clinician during that payment year. By example:

- Performance during the 2017 performance year determines the MIPS adjustment percentage for 2019;
- The adjustment percentage for 2019 will be known no later than December 1, 2018; and
- The negative or positive (including exceptional performance) adjustment will apply to the clinician’s Medicare Part B professional services claims in 2019.

Individual and Group Participation and Reporting Options

Under the final rule, MIPS eligible clinicians can report data and be measured on either an individual or group basis. CMS defines a “group” as a single TIN associated with two or

more eligible clinicians who have their Medicare billing rights reassigned to the TIN for all times during the performance period. So, in 2017, a MIPS eligible clinician must make an initial decision whether to report as individual clinicians or as a group. This designation (as an individual or a group) will remain consistent for each of the performance measure categories (quality, cost, improvement activities, and ACI) used to calculate the MIPS score and, in turn, the payment adjustment.

Where performance is assessed as a group, the performance data of the group’s MIPS eligible clinicians will be aggregated, assessed, and scored across the TIN, including those items and services furnished by individuals who are not MIPS eligible clinicians.

In the final rule, CMS recognized that individuals and groups may have less than 12 months of performance data to report due to naturally occurring events such as changing practices during a performance period or being out on medical leave. It provided that, in such event, these eligible clinicians would report all performance data applicable to the performance period.

MIPS Performance Categories and Scoring

The MIPS score, which determines an eligible clinician’s applicable payment adjustment, is calculated based on the points earned in four performance categories. These performance categories consolidate and streamline components of three existing CMS programs that are scheduled to sunset pursuant to MACRA in 2018 as indicated below. The categories include:

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- Quality (replacing the Physician Quality Reporting System)
- Cost (replacing Value Based Modifier)
- Improvement activities (such as operating a patient centered medical home, promoting care coordination, etc.)
- Advancing care information (replacing the Electronic Health Record (EHR) Incentive Program, also called Meaningful Use or MU).

Under MACRA, CMS is required to establish the MIPS scoring methodology and performance thresholds in advance and in a uniform method that applies across all four performance categories. The final rule confirms that the exact measures and activities for each category will be updated annually.

Under the final rule, CMS will establish a MIPS score for each eligible clinician (or group) for each performance year and assess it against a base or threshold score set by CMS to determine the adjustment to a MIPS eligible clinician’s reimbursement rate during the relevant payment year. The MIPS score will be calculated by aggregating the MIPS eligible clinician’s (or group’s) score from the four performance metrics into a single score, which is then compared to a performance threshold score.

MIPS eligible clinicians that achieve a final score exceeding Medicare’s previously set performance threshold score will receive a positive payment adjustment. MIPS eligible clinicians falling below the final score by a pre-defined performance threshold will receive a negative payment adjustment. Those falling at the performance threshold will receive no payment adjustments.

MACRA requires MIPS to be budget neutral; therefore, CMS annually will score all MIPS eligible clinicians’ final scores in a manner that ensures that all positive, negative, and neutral payment adjustments are budget neutral collectively.

MIPS Performance Categories

The following sections review key requirements of the four MIPS performance categories, with attention to key changes made by CMS in the final rule and other details. The relative weights of the four categories under the final rule over the next few years are summarized in the table below:

Table 3: Performance Categories and Corresponding Percentage Weight for Each Year

MIPS Performance Year and Payment Years	Quality	Cost	Improvement activities	ACI
2017; 2019	60%	0%	15%	25%
2018; 2020	50%	10%	15%	25%*
2019; 2021	30%	30%	15%	25%*
2020; 2022	30%	30%	15%	25%*

*The weight for the ACI category may decrease to as low as 15% if the Secretary determines that the proportion of physicians who are meaningful EHR users is 75 percent or greater. If this reweighting occurs, CMS will reallocate the remaining percentage to one or more of the other categories.

Quality Performance Category

Key themes and changes to the quality performance category under the final rule are summarized below.

Quality Data Submission. CMS finalized its proposal that MIPS eligible clinicians report six measures, including at least one outcome measure. The annual list of quality measures will be published in the Federal Register no later than November 1 of the year proceeding the first day of a performance year. (The final measure set for 2017 can be found in the Appendix of the



final rule.) Updates to the list of quality measures will be made annually through future rulemaking.

In the final rule CMS clarified that if fewer than six measures apply to a MIPS eligible clinician or group, only those applicable measures must be reported. For such purposes, CMS generally defines “applicable” as “measures relative to a particular MIPS eligible clinician’s services or care rendered,” which CMS will determine based on claims data whenever possible.

Additionally, if a MIPS eligible clinician elects to submit data via a specialty-specific measure (e.g., interventional radiology specialty-specific measure set) that has fewer than six measures, the clinician must only submit data on all the measures within that measure set. Conversely, if the measure set contains six or more measures, the eligible clinician is only required to report six measures. CMS will apply a clinical relation test to the quality data submissions to determine if the MIPS eligible clinician could have reported other measures.

MIPS eligible clinicians are required to report at least one outcome measure. If none are available, the MIPS eligible clinician must report on a “high priority” measure – i.e., a measure related to outcomes, patient experience, patient safety, care coordination, cost, and appropriate use.

To provide flexibility during the 2017 transition year, CMS elected not to finalize a requirement that one of the quality measures be a cross-cutting measure. CMS is seeking comments on adding this requirement for MIPS performance year 2018 and beyond.

In the final rule, CMS recommended that MIPS eligible clinicians submit all available data on all measures, not just the required measures. CMS noted that this strategy could increase the MIPS eligible clinician’s final score because CMS will score all measures and use only those that have the highest performance.

To avoid potential “gaming” of the system, CMS will monitor whether MIPS eligible clinicians actively are selecting

submission mechanisms and measure sets with few applicable measures or switching measures to improve their scores as opposed to changing medical goals or patient populations.

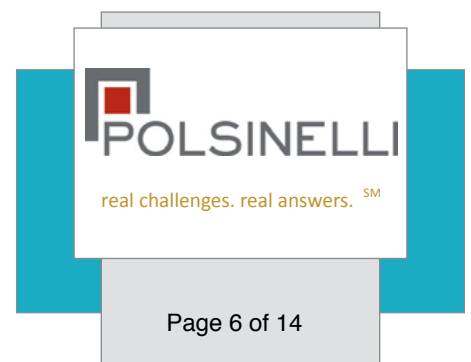
Data Completeness Thresholds. For the quality measure reporting, CMS originally proposed a reporting threshold of 90 percent for Qualified Clinical Data Registry (QCDR) reporting and for 80 percent for claims-based reporting. In its final rule, CMS modified these thresholds. For the 2017 transition year of MIPS, CMS will apply the existing requirements for the PQRS program - a 50 percent data completeness threshold for claims, registry, QCDR, and Electronic Health Records (EHR) submission mechanisms. For the 2018 MIPS performance year, the data completeness threshold will be 60 percent for these submission mechanisms. CMS has targeted a 90 percent reporting threshold and expects to increase the thresholds in future performance years.

Additionally, despite negative comments, CMS finalized its proposal to include all-payer data for QCDR, qualified registry, and EHR submission mechanisms to allow for a more complete picture of each MIPS eligible clinician’s scope of practice and access to data about specialties and subspecialties currently not available via PQRS.

Cost Performance Category

Key changes to the cost performance category are outlined below. Performance in this category will be determined by CMS for MIPS eligible clinicians having at least 20 cases using administrative Medicare claims data.

Cost Measures. For 2017, the cost performance category weight is 0%. Although it will not count toward the final score, CMS will calculate scores on the cost measures and provide





them to MIPS eligible clinicians for informational purposes. CMS limited the final cost measures to those that have been included in either the VBM or the 2014 Supplemental Quality and Resource Use Report.

Episode Based Measures. Overall, CMS reduced the number of episode based measures in the final rule from 41 to 10 and will finalize additional episode-based measures in the future. MIPS eligible clinicians can report on episode-based measures that are not included in this category for 2017 and receive performance feedback from CMS. Some have objected to the inclusion of two of these measures from the VBM, including the total per capita cost, which requires a minimum number of 20 cases to count, and Medicare Spending Per Beneficiary (MSPB) administrative claims cost measure, which requires a minimum number of 35 cases to count. CMS will provide performance feedback for MIPS eligible clinicians who choose to submit additional episode based measures that are not included. This feedback will be for informational purposes only but may help MIPS eligible clinicians understand the measures and attribution rules and has value if CMS chooses to include the measures in future rulemaking.

Acknowledging that clinicians do not oftentimes personally provide, order, or determine the price of all individual services in a cost measure, CMS will continue to assess methods for attributing costs to MIPS eligible clinicians and CMS will continue to evaluate the potential impact of risk factors such as socioeconomic status, on cost measure performance.

Also, CMS is still working to finalize a policy to create benchmarks for the cost measures, including patient condition groups and patient relationship codes to go into effect in 2018 and taking into account potential adjustments required for new technologies.

Attribution. CMS finalized the following arrangement relative to attribution of cost measures:

- Cost measures for all eligible clinicians – whether participating individually or as a group – will be assessed at the individual TIN/NPI level.

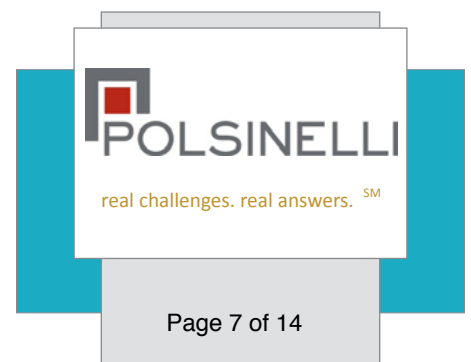
- For groups that participate in group reporting in other MIPS performance categories, the cost performance category point totals will be determined by aggregating the points of the individual eligible clinicians within the TIN.

Improvement Activities Performance Category

The “improvement activity” category (renamed from the proposed rule’s “clinical practice improvement activities” category) represents an area where many physicians and group practices will look to improve their overall MIPS score. Improvement activity measures will account for 15 percent of the MIPS score in the 2017 performance year.

Improvement activities are activities that relevant MIPS eligible clinician organizations and other stakeholders identify as improving clinical practice or care delivery and that CMS determines are likely to result in improved care outcomes. The measures reward clinicians for engaging in activities that focus on care coordination, beneficiary engagement, and patient safety, and for participating in APMs and medical home models.

CMS will publish an annual improvement activities inventory that will define the improvement activities that can be reported for any performance year and the criteria for those activities. CMS is not requiring MIPS eligible clinicians to report a minimum number of improvement activities at this time but is encouraging their reporting generally. CMS lists specific programs and activities that will count toward the improvement activities point total, such as after-hours availability, participation in certain recognized medical home programs, and telehealth activities.





Under the final rule’s scoring rules for the improvement activities performance category, MIPS eligible clinicians must perform an activity for at least 90 days during the performance period to obtain improvement activities credit, and the period may be increased for future performance years. Qualifying activities that are initiated before a performance year or last beyond a performance year’s duration may still qualify, provided that the activity was engaged in for a continuous 90-day period during the performance year.

MIPS eligible clinicians (or groups) who are participating in an APM during the performance year will earn at least 50 percent of the highest potential score for the improvement activities performance category. MIPS eligible clinicians (or groups) that participate in CMS’ study on practice improvement and measurement will receive 40 out of 60 possible points for the improvement activities category after successfully electing, participating in, and submitting data to CMS for the study.

To achieve the highest score (100 percent) on the improvement activities performance category, CMS responded to commentary by decreasing the number of weighted improvement activities necessary from its original proposal of 60 or more points. Under the final rule, the MIPS eligible clinician must attest to two 20-point high-weighted activities, four 10-point medium-weighted activities, or some other combination of high and medium weighted activities equaling 40 points or more to achieve full credit. Those MIPS eligible clinicians that select less than these improvement activities will receive partial credit based on the weighting of the selected improvement activities.

Exceptions to these rules are granted for certain eligible clinicians, including MIPS eligible clinicians representing a group consisting of 15 or fewer clinicians; MIPS eligible clinicians in rural areas or health professional shortage areas; and non-patient-facing MIPS eligible clinicians who report at least one improvement activity. These MIPS eligible clinicians will achieve the full point total for the improvement activities category by reporting one high-weighted or two medium-weighted improvement activities, and a 50 percent score by reporting only one medium-weighted improvement activity. Additionally, non-patient-facing MIPS eligible clinicians earn 30

points for any medium-weighted improvement activity, or 60 points for either one high-weighted or two medium-weighted improvement activities.

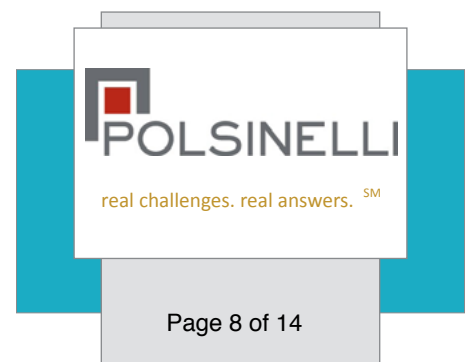
Groups that participate in medical home models or APMs achieve a 100 percent or 50 percent improvement activities score, respectively, by virtue of participation alone. If APM participating clinicians report other improvement activities equivalent to 30 points, they can achieve a 100 percent score on the improvement activities performance category. MIPS eligible clinicians that report no improvement activities will receive a zero score, unless they are a medical home model or a comparable specialty practice.

For the 2017 performance year, CMS identified over 90 activities that MIPS eligible clinicians may choose to participate in for improvement activities credit and increased the number of highly-weighted activities available. The activities are grouped in nine subcategories: expanded patient access; population management; care coordination; beneficiary engagement; patient safety and practice assessment; achieving health equity; integrated behavioral and mental health; emergency preparedness and response; and integration of primary care and behavioral health. CMS will add new subcategories under limited circumstances.

Advancing Care Information Performance Category

The ACI measure will account for 25 percent of the MIPS score in the 2017 performance year.

The ACI performance category scoring is based on 155 possible points (an increase from 131 from the proposed rule) – 50 points for a base score, 90 possible points for a performance score, plus 15 possible bonus points. Once 100 points are





reached, no additional points are counted, and the MIPS eligible clinician receives the full 100 points toward the ACI total used in calculating the MIPS score.

In order to earn points for the ACI performance category, a MIPS eligible clinician must (i) possess certified electronic health record technology (CEHRT), (ii) utilize the functionality of CEHRT, and (iii) report on applicable objectives and measures specified for the ACI performance category for the CMS specified performance period.

Consistent with the goal of creating flexibility and recognizing the incremental steps that MIPS eligible clinicians may take in adopting and using CEHRT, CMS backed off of its proposal that a MIPS eligible clinician must report on all ACI measures to achieve the base score. The final rule requires a MIPS eligible clinician to affirmatively report on just five high priority base score measures, but the MIPS eligible clinician is not required to achieve a certain performance threshold for these base score measures.

ACI Base Score. To receive the 50-point base score, a MIPS eligible clinician must do all of the following:

1. Utilize the required CEHRT during the performance period – typically the full calendar year, except that CMS will accept a minimum of 90 consecutive days of data in 2017 and 2018.
2. Report a numerator (of at least 1) and a denominator or a yes/no statement (a yes statement is required for credit under the base score), as applicable, for each of the 5 following measures:
 - E-Prescribing (MIPS eligible clinicians who write fewer than 100 permissible prescriptions may report a “null” response to the measure or may choose to report a numerator of at least one with a denominator)
 - Security risk analysis
 - Send a summary of care
 - Request/Accept summary of care

- Security risk analysis
 - Provide patient access (note that this measure is different from the view, download or transmit measure which requires that a patient takes action to actually view their information; this measure does not require that the patient take any action)
3. Affirmatively attest to a three-statement attestation to demonstrate support for information exchange and prevention of health information blocking.
 4. Affirmatively attest that he/she acknowledge the requirement to cooperate in good faith and if requested, cooperated in good faith, with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program. There is also an optional attestation that the MIPS eligible clinician engaged in supporting providers with the performance of certified EHR activities as part of the ONC Health IT Certification Program.

If a MIPS eligible clinician does not earn the ACI base score of 50, then the clinician will receive an ACI performance category score of zero.

ACI Performance and Bonus Scores. If an MIPS eligible clinician achieves the 50-point base score, the clinician may then earn an additional performance score of up to 90 points, plus up to 15 bonus points. Because the 90 possible performance points, plus the 50-point base score and 15 potential bonus points exceeds 100, each MIPS eligible clinician has flexibility in meeting measures that are most relevant to his or her practice.

The ACI performance score is based on the level of achievement

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that the clinician shows for each of the following nine measures: provide patient access; patient-specific education; view, download or transmit; secure messaging; patient-generated health data; send a summary of care; request/accept summary of care record; clinical information reconciliation; and immunization registry reporting. A clinician can earn 10 possible points for each of the nine measures.

In 2017 only, if a MIPS eligible clinician reports using the 2017 Advancing Care Information Transition objectives and measures, only the following seven measures will be reported for the performance score: provide patient access; view, download, or transmit; patient-specific education; secure messaging; health information exchange; medication reconciliation; and immunization registry reporting. The provide patient access and the health information exchange measures will both be weighted up to 20 possible points, while 10 points will remain achievable for the other five measures so that if an eligible clinician choose to report using these transitional measures there are still 90 possible performance points available.

The numerator and denominator that are reported for each of the performance measures is converted to a percentage and then converted into points ranging from 0 to 10. A performance rate of 1-10 percent would earn 1 percentage point, a performance rate of 11-20 percent would earn 2 percentage points, etc. For example, if a MIPS eligible clinician has a 75 percent performance rate on a measure, the clinician will receive 8 percentage points towards his or her performance score for that measure.

A MIPS eligible clinician can earn 5 extra bonus points by reporting “yes” for any of the measures under the Public Health and Clinical Data Registry Reporting objective (except for the Immunization Registry Reporting measure, which is a separate measure for purposes of the performance score). A MIPS eligible clinician is not required to report the Immunization Registry Reporting measure as part of its performance score in order to earn the bonus points for reporting to other registries. A MIPS eligible clinician can also earn 10 bonus points for reporting at least one improvement activity using CEHRT.

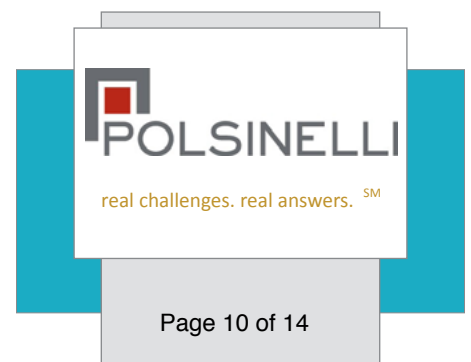
The sum of the base score, performance score and extra bonus points earned will be converted to the 25 possible ACI performance category points. For example, if a MIPS eligible clinician’s aggregate base, performance and bonus score is 80, then the ACI portion of the MIPS eligible clinician’s MIPS APS will be 20 (which is 80 percent of 25).

CEHRT Requirements. To achieve the ACI performance category base score in 2017, a MIPS eligible clinician must use either 2014 or 2015 Edition CEHRT or a combination of the two during the performance period. If a MIPS eligible clinician switches from 2014 Edition to 2015 Edition CEHRT during the performance period, the data collected in each edition should be combined for purposes of reporting on the relevant ACI measures. Depending on what edition of CEHRT the MIPS eligible clinician utilizes in 2017, the MIPS eligible clinician may have the choice of reporting on the 2017 Advancing Care Information Transition objectives and measures.

Beginning in 2018, MIPS eligible clinicians will be required to use 2015 Edition CEHRT and meet the MIPS objectives and measures that generally correlate to the Meaningful Use Stage 3 requirements in order to achieve the ACI base score.

Data Submission. MIPS eligible clinicians can submit ACI performance category data through multiple submission methods -- qualified registries, EHR, QCDR, attestation, and CMS Web Interface submission methods. Eligible clinicians can also submit data on either an individual level or the data may be aggregated and submitted at the group level.

In group reporting, if an individual eligible clinician meets the criteria to exclude a measure, his or her data can be excluded from the calculation of that particular measure only. When aggregating data for group reporting, the numerators and





denominators for each MIPS eligible clinician can merely be added together; there is not a requirement that the group determine that a patient seen by one MIPS eligible clinician within a group is also not seen by another MIPS eligible clinician within the group.

Because of the uncertainty of whether the measures specified for the ACI performance category will be applicable and available to non-physician MIPS eligible clinicians, a weight of zero will automatically be assigned to the ACI performance category for non-physician MIPS eligible clinicians who do not submit any data for any of the measures, and the other APS performance categories will be reweighted. If a non-physician MIPS eligible clinician, however, chooses to report on ACI measures, then his or her scoring on the ACI performance category will be like that of the physician MIPS eligible clinicians. After the 2017 MIPS performance period, CMS will evaluate the continued participation of non-physician MIPS eligible clinicians in the ACI performance category.

Re-Weighting. CMS recognized that an insufficient number of ACI measures may be applicable to hospital-based MIPS eligible clinicians. As such, a weight of zero will automatically be assigned to the ACI performance category for hospital-based MIPS eligible clinicians, and the other MIPS performance category scores will be re-weighted to make up the difference.

The final rule defines hospital-based MIPS eligible clinicians as clinicians who furnish 75 percent (reduced from 90 percent in the proposed rule) or more of their covered professional services in an inpatient, on-campus outpatient, or emergency room setting, as identified by place of service codes 21, 22, and 23 on submitted claims.

Under the final rule, even if a MIPS eligible clinician meets

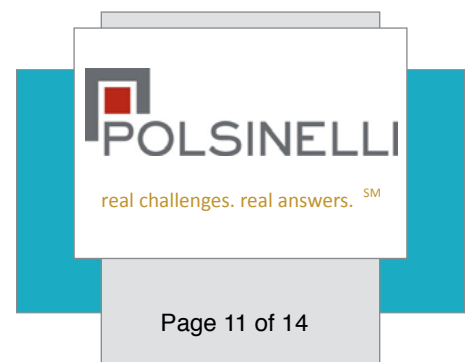
the definition of hospital-based, if he or she determines that there are sufficient ACI measures applicable to his or her practice such that reporting is possible, he or she may choose to report on the ACI measures; however, if he or she exercises this option, then the ACI performance category scoring methodology and weight will be the same as that for all other MIPS eligible clinicians. Similar re-weighting of the ACI performance category will be applied for non-patient facing eligible clinicians.

CMS also may re-weight the ACI performance category in the following instances, upon the application and demonstrated need for re-weighting by the MIPS-eligible clinician:

1. Insufficient internet
2. Extreme and uncontrollable circumstances (e.g., a natural disaster that destroys the EHR)
3. Lack of control over the availability of EHR technology

MIPS eligible clinicians may request a re-weighting of the ACI performance category for these reasons on a rolling basis, but the applications must be submitted no later than the close of the submission period for the relevant performance period (i.e., March 31, 2018 for the 2017 performance period) or a later date specified by CMS.

As discussed above, MACRA provides that, if in any year, CMS estimates that the proportion of eligible clinicians who are “meaningful EHR users” is 75 percent or greater, the Secretary may reduce the applicable percentage weight of the ACI performance category in the MIPS CPS, but not below 15 percent. The definition of a “meaningful EHR user” for this purpose is a physician eligible clinician who has earned an ACI





performance category score of at least 75% for a performance period. Physicians for whom the ACI performance category is weighted to zero will not be included in the meaningful EHR user's calculation.

CMS expects to adopt changes to the ACI scoring methodology over time to reflect MIPS eligible clinicians' performance and the evolution of CEHRT, to potentially include establishing benchmarks for MIPS eligible clinicians' performance on the ACI performance category.

The final rule does not have any effect on participation in the Medicaid Electronic Health Record Incentive Program and MIPS eligible clinicians who participate in that program will continue to be eligible for incentive payments through 2021. Additionally, the final rule does not replace or affect the application of the meaningful use program for hospitals.

Observations and Additional Information

In the final rule CMS sought to balance several potentially conflicting goals and objectives:

- The agencies' self-defined goal to set priorities and timelines to link 90 percent of Medicare FFS payments to quality or value by the end of 2018,
- Massive amounts (over 4,000) public comments from stakeholders in response to the highly complex proposed rule; and
- A practical need and legislative mandate to begin implementing the bi-partisan MACRA legislation beginning on Jan. 1, 2017.

Overall, given the complexity of MACRA, the final rule and the 2017 transition plan for MIPS in particular represents a pragmatic, but imperfect, approach to implementation. On this final point, CMS observes and acknowledges that the final rule and the specific details of the MIPS and APM participation vehicles for the QPP will continue to change and evolve in the years ahead.

Consult Polsinelli's separate articles dealing with the final rule's requirements and practical implications associated with APMs and MIPS [here](#).

The final rule is subject to a 60-day comment period following its publication in the Federal Register on Nov. 4, 2016, so comments are due on Dec. 19, 2016.

Sign up to participate

Nov. 10, 2016

Polsinelli Reimbursement Institute Webinar: MACRA Final Rule: Key Implications and Strategies for Success, presented by Bruce A. Johnson and Sidney Welch. <http://www.polsinelli.com/intelligence/webinar-ri-macra-final-rule-johnson-welch>





For More Information

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