2017 MACRA Final Rule
Implications for Health Care IT Vendors

Naomi Levinthal, MA, MS, CPHIMS
Practice Manager

December 15, 2016
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2017 MACRA Final Rule
Implications for Health Care IT Vendors

Naomi Levinthal, MA, MS, CPHIMS
Practice Manager

December 15, 2016
Key Points from the Final Rule

1. Greatest MACRA Challenges for Providers
2. Considerations for Health Care IT Vendors
Considerations for Health IT Vendors

1. Understand MACRA’s\(^1\) impact
   - Assess portfolio for implications
   - Develop messaging to explain position/offerings

2. Encourage aligned submission methods
   - Port client data to CMS\(^2\)
   - Offer capabilities that earn credit across categories

3. Invest in resources to stay current on MACRA
   - Act as trusted information source for clients
   - Ensure information is up to date with new rulemaking

4. Utilize Advisory Board resources
   - Request presentation assistance for your clients
   - Rely on us for your MACRA research

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\(^1\) MACRA = Medicare Access and CHIP Reauthorization Act of 2015.

\(^2\) CMS = Centers for Medicare & Medicaid Services.
MACRA: How the Final Rule Impacts Providers

The basic framework CMS plans to use to implement MACRA in 2017

- The most important changes in the final rule
- Next steps for provider organizations in response to MACRA

2017 MACRA Final Rule Detailed Analysis: Your Guide to the Transition Year

The details of 2017 MIPS/APM requirements

- Action items on reporting and program management
- Important areas for public comment

For more Advisory Board resources on MACRA, visit advisory.com/macra

1) MIPS/APM = Merit-based Incentive Payment System/Alternative Payment Model.
MACRA Kicks Off in 2017, Affects 2019 Payments

Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) Implementation Timeline

April 16, 2015
MACRA signed into law

June 27, 2016
Comment period on proposed rule closes

January 2017
Performance period begins that will determine applicable MIPS or APM track; additional performance periods offered

April 27, 2016
CMS released proposed rule with details for MIPS\(^1\) and APM\(^2\) tracks and call for comments

October 14, 2016
CMS released final rule with comment period

January 2019
First year of physician payment adjustment under MIPS or APM

MACRA in Brief

- Legislation passed in April 2015 that repealed the Sustainable Growth Rate (SGR)
- Locks Medicare Part B payment rates at near zero growth: 0.5% increase from 2015–2019; 0.0% increase from 2020–2025; 0.25% increase from 2026 and on for MIPS participants
- Extra $500M for exceptional performers under MIPS; APM bonuses range from $146M to $429M

1) MIPS = Merit-based Incentive Payment System.
2) APM = Alternative Payment Model.

Sources: CMS; Advisory Board research and analysis.
MACRA Here to Stay, Consolidates Existing Programs

MACRA Consolidates Previous Quality Reporting Programs for Medicare Clinicians

<table>
<thead>
<tr>
<th>Physician Quality Reporting System (PQRS)</th>
<th>Value-Based Payment Modifier (VBPM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR Incentive Programs (aka Meaningful Use)</td>
<td>MACRA: MIPS/APM</td>
</tr>
</tbody>
</table>

**MACRA Legislation Received Strong Bipartisan Support**

- **Senate vote in favor of MACRA**: 92-8
- **House vote in favor of MACRA**: 392-37

**On-demand Post-Election Webconference**

Listen to our webconference on “The Post-Election Outlook for Health Policy”
MACRA Creates CMS Quality Payment Program

**CMS Quality Payment Program**

- **Advanced Alternative Payment Models (Advanced APM)**
  - **Financial incentives:** 5% annual bonus in 2019–2024, and 0.75% annual payment increase from 2026 on
  - **Exempt from MIPS payment adjustments**

- **Merit-Based Incentive Payment System (MIPS)**
  - **Performance based on 4 categories:** Quality, Cost, IA, and ACI
  - **Payment adjustments** reach -9% / +27% by 2022

**MACRA Does Not Impact MU for Hospitals, Medicaid EPs**

MU as defined by Modified Stage 2 and Stage 3 regulation and subsequently modified under the 2017 OPPS rule, continues on for hospitals and Medicaid EPs

On-demand MU Webconference: 2016–2018 Requirements

Listen to our webconference on “2016–2018 Meaningful Use Modifications: Highlights from the Hospital Outpatient Prospective Payment System Final Rule”

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1) Previously referred to as the Resource Use category; 2) Previously referred to as the Clinical Practice Improvement Activities category; 3) ACI = Advancing Care Information; 4) EPs = Eligible professionals; 5) OPPS = Hospital Outpatient Prospective Payment System.

Sources: CMS, “Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models,” 81 FR 77008, November 4, 2016, [https://www.federalregister.gov/d/2016-25240](https://www.federalregister.gov/d/2016-25240); Advisory Board research and analysis.
## A Sweeping Impact Across Providers

Yet Awareness and Appreciation of MACRA’s Impact Is Low

### Included

- Medicare Part B payments (i.e., clinician professional payments)
- Physicians, PAs, NPs, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists
- Groups that include any of the above clinicians

### Excluded

- Medicare Part A (i.e., inpatient, outpatient technical hospital payments)
- Clinicians, groups that fall under low volume threshold:
  - $30,000 or less in Medicare charges OR
  - 100 or fewer Medicare patients
- Providers in their first year billing Medicare

<table>
<thead>
<tr>
<th>Included</th>
<th>Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>712K</strong></td>
<td><strong>124K</strong></td>
</tr>
<tr>
<td>Clinicians impacted by MACRA per CMS estimate</td>
<td>Additional excluded clinicians per Final Rule</td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>50%</strong></td>
<td>Physicians surveyed unaware of MACRA</td>
<td></td>
</tr>
</tbody>
</table>

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1) PAs = Physician assistants.  
2) NPs = Nurse practitioners.  
3) We note that additional provider types are included for APM track qualification: certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, physical or occupational therapists, qualified speech-language pathologists, and qualified audiologists; and a group that includes these professionals.

Sources: CMS; Deloitte, 2016 US Survey of Physicians, available at deloitte.com; Advisory Board research and analysis.
Important Not to Crawl in MIPS

Aim to Run in MIPS; Non-Reporters Face Stiff Penalty

1. “Crawl” Option
   - Submit minimum data for a single category
   - Avoid a negative payment adjustment

2. “Walk” Option
   - Submit more than minimum data for at least 90 days
   - May qualify for nominal positive payment adjustment

3. “Run” Option
   - Submit all required data for at least 90 days
   - May qualify for modest positive payment adjustment

Requirements Eased in Final Rule, But Only for Short Term

- “Pick your pace” reporting options in 2017
- Increased exclusion thresholds for “low-volume” providers
- All clinicians should be well poised to avoid downward payment adjustments

2019 MIPS Potential Penalties¹

- Small Practice (20 providers) $116K
- Medium Practice (50 providers) $240K
- Large Practice (100 providers) $321K

¹ Projections based on CMS’s estimates included in Table 64 of the MIPS/APM proposed rule; MIPS Proposed Rule Estimated Impact On Total Allowed Charges By Practice Size.
APM Payment Track Looks Enticing

Baseline Payment Adjustments Under Each Track

- **2015–2019**: 0.5% annual update
- **2020–2025**: Frozen payment rates

**Alternative Payment Model Track**: 2026 and on 0.75% annual update

**The Merit-Based Incentive System**: 2026 and on 0.25% annual update

**2019–2024**: APM track participants receive 5% annual bonus

**Annual Bonus for APM Participation**

5% Bonus awarded each year from 2019–2024 to clinicians who qualify for the APM track

Sources: CMS; Advisory Board research and analysis.
Strict Advanced APM Eligibility Requirements

Advanced APMs Confirmed for 2017

Advanced APM Criteria

- **Financial Risk Criteria**
  - Meet revenue-based standard (average of at least 8% of revenues at risk for participating APMs) or
  - Meet benchmark-based standard (maximum possible loss must be at least 3% of spending target)
  - Certified EHR use
  - Quality requirements comparable to MIPS

2017 Medicare Advanced APMs

- Comprehensive ESRD\(^1\) Care LDO\(^2\) Arrangement
- Comprehensive ESRD Care non-LDO Arrangement (two-sided risk)
- CPC+\(^3\)
- MSSP\(^4\) Track 2 and Track 3
- Next Generation ACO\(^5\)
- Oncology Care Model (OCM, two-sided risk arrangement)

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1) ESRD = End-stage renal disease.
2) LDO = Large dialysis organization.
3) CPC+ = Comprehensive Primary Care Plus.
4) MSSP = Medicare Shared Savings Program.
5) ACO = Accountable care organization.

APM Entity Must Meet Qualifying Participant Status

Variation in Volume Can Make or Break APM Track Determination

APM Entities Must Meet Percent of Payments or Patient Counts

<table>
<thead>
<tr>
<th>Year</th>
<th>Payments</th>
<th>Patient Counts</th>
</tr>
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<tbody>
<tr>
<td>2019</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>2022</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>2023</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>2024+</td>
<td>75%</td>
<td>75%</td>
</tr>
</tbody>
</table>

Example of 2019 Payment Qualification:

- APM Entity 1: Payments = 21%
- APM Entity 2: Payments = 33%

Defining Partial QPs:
- Do not meet QP thresholds but meet slightly lower thresholds, excluded from APM track
- Partial QPs can opt in or out of MIPS track, proactive notification to CMS required to opt in

Sources: CMS; Advisory Board research and analysis.
## 2017 MIPS Performance Categories Executive Summary

<table>
<thead>
<tr>
<th>Category</th>
<th>Key Components</th>
<th>Scoring &amp; Weight&lt;sup&gt;1&lt;/sup&gt;</th>
</tr>
</thead>
</table>
| Quality (Previously PQRS)     | • Over 200 measures to choose from, 80% of which are tailored to specialists  
• Providers required to report six measures, including one outcome measure; in addition, all-cause readmissions will be calculated based on claims for certain providers | Based on peer benchmarks 60% |
| Cost (Previously VBPM cost component) | • Not a component of MIPS performance in program year 2017  
• CMS will include this category beginning 2018                                                                                              | 0%                            |
| Improvement Activities (New category) | • Over 90 activities to choose from; offers flexibility for many provider types  
• Preferential scoring for small practices, MIPS APM participants, and PCMH<sup>2</sup>                                                                 | Based on EC’s own performance 15% |
| Advancing Care Information (Previously MU) | • Applies to additional clinicians,<sup>3</sup> unlike previous Medicare Eligible Professional MU requirements (which applied only to physicians)  
• No longer requires “all-or-nothing” measure threshold reporting; clinicians scored on participation and performance | Based on EC’s own performance 25% |

**621K** Clinicians currently projected by CMS subject to the MIPS track for the 2019 payment year

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1) Different weights apply to MIPS APM scoring standard; 2) PCMH = Patient-Centered Medical Homes; 3) MIPS-eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such clinicians. In 2017, Advancing Care Information (ACI) category may be reweighted to zero for non-physician clinicians; 4) EC = Eligible clinician.

Sources: CMS; Advisory Board research and analysis.
“Special” MIPS APM\(^1\) Scoring in MIPS

Different Category Weights for ECs Without QP Status or in MIPS APMs

**Comparison Between MIPS and MIPS APM Category Weights in 2017**

<table>
<thead>
<tr>
<th>Category</th>
<th>MIPS</th>
<th>MSSP</th>
<th>Next Gen</th>
<th>Other APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
<td>25%</td>
</tr>
<tr>
<td>Cost</td>
<td>15%</td>
<td>20%</td>
<td>20%</td>
<td>75%</td>
</tr>
<tr>
<td>Improvement Activities (IAs)</td>
<td>25%</td>
<td>30%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Advancing Care Information (ACI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MIPS APM Scoring Standard**

- Quality
- Cost
- Improvement Activities (IAs)
- Advancing Care Information (ACI)

**Applies\(^2\) to Two MIPS EC Scenarios**

1. Below QP Volume Threshold in Advanced APM
2. Any Volume in MIPS APM

**2017 Medicare Advanced APMs**

- Comprehensive ESRD\(^1\) Care LDO Arrangement
- Comprehensive ESRD Care non-LDO Arrangement (two-sided risk)

**2017 MIPS APMs**

- MSSP Track 1
- MSSP Tracks 2 and 3
- Next Generation ACO
- OCM (two-sided risk arrangement)

---

1) CMS defines a MIPS APM as an APM that meets the following criteria: (1) APM Entities participate in the APM under an agreement with CMS or by law or regulation; (2) the APM requires that APM Entities include at least one MIPS-eligible clinician on a Participation List; and (3) the APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on cost/utilization and quality measures.

2) Participant list snapshots taken on March 31, June 30, August 31, 2017. Each snapshot adds participants, never reverses previous designation.

Sources: CMS; Advisory Board research and analysis.
MIPS Payment Adjustments: 3 Is the “Magic Number”

Strong Performers Benefit at Expense of Non-Reporters

Payment Adjustment Determination

1. ECs assigned score of 0–100 based on performance across three categories

2. Score compared to CMS-set performance threshold (PT); non-reporting groups given lowest score

3. A score above PT results in upward payment adjustment; a score below PT results in a downward adjustment

Maximum EC Penalties and Bonuses

2019 PT Established per Final Rule
CMS set the PT to 3 to avoid a negative payment adjustment, and 70 to earn exceptional performance bonus.

1) Payment adjustment size corresponds with how far the score deviates from the PT.

2) Additional pool of $500M available for exceptional performers to receive additional incentive of up to 10% for MIPS-eligible providers that exceed the 25th percentile above the PT.

Sources: CMS; Advisory Board research and analysis.
Key Points from the Final Rule

Greatest MACRA Challenges for Providers

Considerations for Health Care IT Vendors
Your Clients’ “GUIDE” to MACRA

Advisory Board’s Advice to Address Provider’s Challenges

G - Gear up, get ready for MACRA “sea change”

U - Understand MACRA requirements

I - Inflect performance to improve MIPS standing

D - Develop MACRA strategy

E - Engage with CMS to submit public comment
1) Gear up, get ready for MACRA “sea change”

**MACRA Part of Public Payer “Sea Change”**

**Major Health Care Reform Goals**

1. **Replace Costly Fee-for-Service Incentive Structures**
   - Chosen Method: **Medicare-Led Payment Reform**
     - FFS¹ cuts
     - New payment models
     - Intent to catalyze broader commercial market change

2. **Improve Health Care Quality**
   - Chosen Method: **Incentives and Transparency**
     - IT mandates
     - Pay-for-performance programs
     - Market-facing transparency

3. **Achieve Universal, Affordable Coverage**
   - Chosen Method: **Expansion of Existing System**
     - Insurance market regulation
     - Expanded public coverage
     - Market-based exchanges

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1) FFS = Fee for service.

Source: Advisory Board research and analysis.
Detailed Resources Available

Appendix
2017 MACRA Final Rule Detailed Analysis

Appendix Available at:
https://www.advisory.com/Research/Health-Care-IT-Advisor/Events/Webconferences/2016/2017-MACRA-Final-Rule-Detailed-Analysis

- Acronym List
- APM QP Calculation Information
- MIPS Performance Category Guides
- Pocket Guides for MIPS ACI Measures
- MIPS Reporting for MSSP and Next Generation ACOs
Clients Must Aim for Highest Possible Performance

Most Categories Derive from an Existing CMS Program

1. **Quality**
   - Gauge performance on PQRS measures, and consider new MIPS measures

2. **Cost**
   - Evaluate episode cost measures on QRUR\(^1\) per VBPM requirements

3. **IA**
   - Assess CMS inventory to determine which improvement activities are currently performed

4. **ACI**
   - Review MU dashboards and analyze performance under new scoring methodology

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Review 2017 Finalized MIPS Measures

See Health Care IT Advisor tool, “2017 MIPS Measures” (November 2016)

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1) QRUR = Quality and Resource Use Reports.

Source: Advisory Board research and analysis.
Which Pace Will Your Client Pick?

Plan an Approach Based on Experience with Existing CMS Programs

- **Neither PQRS nor MU**
  - Avoid negative payment adjustment
  - **IA.** At minimum, report at least one activity
  - **Quality.** Report at least one measure, if possible
  - **ACI.** Report ACI minimum requirements, if technically feasible

- **Either PQRS or MU**
  - Potentially earn small positive adjustment
  - **IA.** Achieve full performance
  - **Quality.** Engage EHR vendor or registry\(^1\) to report, if feasible, and maximize performance and bonus points
  - **ACI.** Report minimum ACI requirements, if feasible, and maximize performance and bonus points

- **Both PQRS and MU**
  - Aim for exceptional performance\(^2\)
  - **IA.** Achieve full performance, and prioritize reporting activities that use CEHRT\(^3\)
  - **Quality.** Maximize performance and bonus points
  - **ACI.** Maximize performance and bonus points

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1) For example, Qualified Registry or QCDR (Qualified Clinical Data Registry).
2) Additional pool of $500M available for exceptional performers that achieve a MIPS Composite Performance Score that exceeds 70 for the 2017 performance period.
3) CEHRT = Certified electronic health record technology.
Vendors and Clients Should Make Their Voices Heard

Set Aside Resources to Review and Comment on Annual Changes

### Key Considerations for Public Comment

- ** Eligible clinician definition. ** CMS may expand ECs to include additional types of providers (e.g., physical therapists) in year 3 and beyond.
- ** APM track. ** Non-Medicare APMs’ contribution toward QP determinations in year 3 and beyond.
- ** Virtual groups. ** CMS has yet to establish virtual groups to assist solo and small practices in MIPS.
- ** Facility-based clinicians. ** Policies to apply a facility’s performance to a MIPS clinician have yet to be determined.
- ** MIPS APM scoring. ** CMS has yet to determine Quality scoring methodology for non-MSSP, non-Next Generation ACO payment models.
- ** MIPS Quality category. ** Maximum score for topped-out measures may be limited in future years.
- ** MIPS Cost category. ** CMS will include new episode-based measures and potentially Part D drug costs.

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**Annual MIPS/APM Rulemaking Expected**

- **November**
  - CMS publishes annual MIPS/APM Final Rule

- **January**
  - Performance period starts two months after requirements are finalized

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**Public comment closes on December 19, 2016** for the MIPS/APM final rule with comment period.
1. Key Points from the Final Rule

2. Greatest MACRA Challenges for Providers

3. Considerations for Health Care IT Vendors
Considerations for Health IT Vendors

1. Understand MACRA’s impact
   - Assess portfolio for implications
   - Develop messaging to explain position/offerings

2. Encourage aligned submission methods
   - Port client data to CMS
   - Offer capabilities that earn credit across categories

3. Invest in resources to stay current on MACRA
   - Act as trusted information source for clients
   - Ensure information is up to date with new rulemaking

4. Utilize Advisory Board resources
   - Request presentation assistance for your clients
   - Rely on us for your MACRA research
Understand MACRA’s Impact

Assess Portfolio Position

Assemble product management and strategy staff to assess how and if MACRA impacts portfolio position

Identify Clients’ Needs

Seek out input on product functions that will support clients’ transition to MACRA, and add to roadmap, if applicable

Market Solution/Services

Get your message to existing and new, relevant audiences once solution/services are developed

Providers Impacted by MACRA Need MIPS Reporting Software

• Identify and track eligible and excluded clinicians
• Forecast financial penalties
• Offer individual and group reporting options
• Display current performance
• Monitor trends and incorporate CMS benchmarks
• Suggest how to improve standing
New “Health IT in the QPP” Checklist for Vendors

Clear Messaging Is Key, One-Page to Share with Clients Available Now

Health IT in the QPP

Editable One-Pager

- Ready-to-go educational content for clients/prospects
- Two quick customizations:
  - Update your company name
  - Keep/delete the check-box icons that apply to your offerings

Download at:
https://www.advisory.com/Research/Health-Care-IT-Advisor/Events/Webconferences/2016/2017-MACRA-Final-Rule-Implications-for-Health-Care-IT-Vendors

1) Understand MACRA’s impact
ABCs of Submission Mechanisms in MIPS

2) Encourage aligned submission methods

- **Qualified Registry**
  - Meets specific CMS qualifications and scope of registry is limited to MIPS measures
  - For more: MIPS Qualified Registry Self-Nomination Fact Sheet

- **Qualified Clinical Data Registry (QCDR)**
  - Meets specific CMS qualifications but scope of registry is *not* limited to MIPS measures
  - For more: MIPS QCDR Self-Nomination Fact Sheet

- **EHR**
  - Office of the National Coordinator-certified EHR submits data directly to CMS
  - For more: certified EHRs available

- **CMS Web Interface**
  - Group practice reporting option via CMS' QualityNet website
  - For more: see QualityNet

- **Attestation or Claims**
  - Attestation: TBD; CMS may utilize existing MU attestation portal
  - Claims: Coded data inputted through claims

- **CAHPS¹ Vendor**
  - CMS-certified vendor used for combined CAHPS and MIPS reporting
  - For more: see currently approved vendors

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1) CAHPS = Consumer Assessment of Health Providers and Systems.

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Sources: CMS; Advisory Board research and analysis.
## MIPS Reporting Alignment Options

### MIPS Data Submission Mechanisms: Report Individually or as a Group

<table>
<thead>
<tr>
<th>Submission Methods</th>
<th>Qualified Registry</th>
<th>QCDR</th>
<th>EHR</th>
<th>CMS Web Interface</th>
<th>Attestation</th>
<th>Claims</th>
<th>CAHPS Vendor</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>ACI</td>
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### Offer Reporting Across Categories, and for...

#### All Vendors
- Prepare for CMS vendor audits
- Recognize that failed audits jeopardize clients’ MIPS compliance

#### EHR Vendors
- Leverage existing MU reporting capabilities to display new ACI scoring
- Aggregate data for group reporting option

#### Registry Vendors
- Attain CMS approval to claim 2017 MIPS Qualified Registry and QCDR readiness
- Devote resources to comply with annual nomination process

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Note: the **dark box** denotes submission methods that allow reporting alignment opportunity.

1) Available for groups of 25 or more only.
2) Available for individual reporting only.
3) For groups only; must be a CMS-approved survey vendor for MIPS.

Sources: CMS; Advisory Board research and analysis.
Quality Reporting Resources to Support You

Webconferences
- MACRA: How the Final Rule Impacts Providers
- 2016-2018 Meaningful Use Modifications
- 2017 MACRA Final Rule Implications for Health Care IT Vendors
- The No-Regrets Approach to MACRA: How to Prepare During Rulemaking

Tools
- 2017 Merit-Based Incentive Payment System Measures
- Your questions about the MACRA proposed rule—answered
- Health Care IT Advisor MACRA Cheat Sheet
- MACRA Cheat Sheet for Industry

Research
- Build Efficient Quality Reporting with Streamlined Quality and IT Efforts
- 5 Steps to Succeed in the MIPS Quality Category
- Meaningful Use gets a facelift under MACRA—but is it better? Here's our view
- 2016 Eligible Professional Quality Reporting: CMS Offers More Flexible Reporting Options, But It's Time to Align

For These and Forthcoming Resources on MACRA:
https://www.advisory.com/macra
# Level of Familiarity with MACRA Depends on Role


<table>
<thead>
<tr>
<th>Role</th>
<th>Familiarity with MACRA</th>
<th>Advisory Board Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marketing or Sales Associate</td>
<td>Need the least amount of detailed MACRA knowledge, but must be conversant in current product functionality</td>
<td>Health Care IT Advisor MACRA Cheat Sheet</td>
</tr>
<tr>
<td>Senior Product Manager</td>
<td>Appreciates “10,000-foot view” and specific requirements simultaneously to drive product roadmap and development</td>
<td>MACRA: How the Final Rule Impacts Providers</td>
</tr>
<tr>
<td>Client Relationship Manager</td>
<td>Should be most “scrubbed in” on MACRA details to provide guidance on current product functionality and QPP requirements</td>
<td>2017 MACRA Final Rule Detailed Analysis: Your Guide to the Transition Year</td>
</tr>
</tbody>
</table>

Source: Advisory Board research and analysis.
Utilize Advisory Board Resources

Contact Your Dedicated Advisor for Assistance

Consult with experts about **product strategy** and/or for orientation on MACRA and its related regulations.

Send a question to confirm understanding of regulatory requirements; obtain references for both internal and external use.

Request presentation for clients by Advisory Board experts; education can make messaging consistent.

Access **educational resources** for internal staff and strategic development; Cheat Sheet series very popular.

Stay informed of new regulatory and legislative implications for your product(s) with **subscription alerts**.

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**Cheat Sheet Series**

See Health Care Industry Committee [Cheat Sheets](#)
Key Takeaways for Health Care IT Vendors

2017 Transitional Year for Providers, and Also for Vendors

**MACRA Has Significant Impact**

The bipartisan supported-law fundamentally changes how Medicare pays providers and it is unlikely to be repealed.

**Most Providers Will Be in MIPS**

Tailor your services/products to MIPS; CMS estimates that at least 84% of Medicare providers nationwide will fall in this track in 2017.

**Opportunities Exist to Support Providers with Your Services/Solutions**

Health IT systems are critical to MACRA success; providers have yet to establish clear strategy.

**Plan for Final Rule and Annual Rulemaking**

Health care IT vendors should prepare to revisit MACRA plans in November; plan for yearly updates via rulemaking.

Source: Advisory Board research and analysis.
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