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Utilizing Exceptions for CEHRT Compliance Requirements in ACO REACH & the Shared Savings Program

As ACOs in the SSP and ACO REACH Model work to ensure compliance with increasingly stringent CEHRT Requirements in Performance Year 2025, we have seen an increase in questions related to the availability of exceptions.

CEHRT requirement exceptions to ACOs include:

Low Volume Threshold Exception

Failure to meet the low volume threshold as defined in 42 CFR § 414.1305. The low-volume threshold applies to an individual eligible clinician, or group that, during the MIPS determination period:

- has allowed charges for covered professional services less than or equal to $90,000,
- furnishes covered professional services to 200 or fewer Medicare Part B-enrolled individuals, or
- furnishes 200 or fewer covered professional services to Medicare Part B-enrolled individuals.

There is no action required for the ACO to utilize this exception. However, you should be prepared to provide documentation to prove that the eligible clinician or group falls within this threshold in the event of an audit.

Reweight of Promoting Interoperability Performance Category Exception*

Qualifies for reweighting of the MIPS Promoting Interoperability performance category to zero percent of the final score, in accordance with 42 CFR §414/1380(c)(2)(i) for the applicable year.

Exception for Eligible Clinicians who are not MIPS Eligible Clinicians*

Is an eligible clinician as defined in 42 CFR § 414.1305 and is not a MIPS eligible clinician as defined in 42 CFR § 414.1310(b)(2), provided they cannot be excluded solely on the basis of being a Qualifying APM Participant or a Partial Qualifying APM Participant.

*** Continue reading for additional information on these exceptions**

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Reweight of Promoting Interoperability Performance Category Exception

This exception applies when the clinician or group:

Qualifies for reweighting of the MIPS Promoting Interoperability performance category to zero percent of the final score, in accordance with 42 CFR §414/1380(c)(2)(i) for the applicable year.

There are a number of exceptions listed at 42 CFR §414/1380(c)(2)(i), many of which require proactive application to CMS prior to utilization. Under this section, the clinician or group may be able to claim an exception if:

A. CMS determines, based on a list of circumstances specified in the section, that there are not sufficient measures and activities applicable and available;
B. CMS estimates that the proportion of MIPS eligible clinicians who are physicians as defined in section 1861(r) of the Social Security Act and earn a Promoting Interoperability performance category score of at least 75 percent is 75 percent or greater.
C. A significant hardship exception or other type of exception is granted to a MIPS eligible clinician based on one of the following circumstances (*Exceptions notated with an asterisk (*) require an application submitted to CMS*):
    1. The clinician lacked sufficient internet access during the performance period, and insurmountable barriers prevented the clinician from obtaining sufficient internet access*;
    2. The clinician was subject to extreme and uncontrollable circumstances that caused their CEHRT to be unavailable*;
    3. The clinician was located in an area affected by extreme and uncontrollable circumstances as identified by CMS;
    4. 50 percent or more of the clinician's outpatient encounters occur in practice locations where they had no control over the availability of CEHRT*;
    5. The clinician is a non-patient facing clinician as defined in §414.1305
        i. Beginning with the 2021 MIPS payment year this includes:
            1. an individual MIPS eligible clinician who bills 100 or fewer patient facing encounters (including Medicare telehealth services defined in section 1834(m) of the Act), during the MIPS determination period, and
            2. a group or virtual group provided that more than 75 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable, meet the definition of a non-patient facing individual MIPS eligible clinician

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Reweight of PI Performance Category Exception, Continued

   ii. For purposes of this definition, a patient-facing encounter is an instance in which the individual MIPS eligible clinician or group bills for items and services furnished such as general office visits, outpatient visits, and procedure codes under the PFS, as specified by CMS.

6. The clinician is a hospital-based clinician as defined in §414.1305
   i. Beginning with the 2022 MIPS payment year, a hospital-based clinician is one who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the POS codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, off campus outpatient hospital, or emergency room setting based on claims for the MIPS determination period, and a group or virtual group provided that more than 75 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable, meet the definition of a hospital-based individual MIPS eligible clinician during the MIPS determination period.
7. The clinician is an ASC-based clinician as defined in §414.1305
   i. Beginning with the 2021 MIPS payment year, an ASC-based clinician is one who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the POS codes used in the HIPAA standard standard transaction as an ambulatory surgical center setting based on claims for the MIPS determination period.
8. The clinician's CEHRT was decertified during the performance period for the MIPS payment year or during the calendar year preceding the performance period for the MIPS payment year, and the clinician made a good faith effort to adopt and implement another CEHRT in advance of the performance period*;
   i. Note: This exception may not be granted for more than five (5) years.
9. Beginning with the 2024 MIPS payment year: The clinician is in a small practice as defined in §414.1305.
   i. a small practice is a TIN consisting of 15 or fewer eligible clinicians
10. CMS determines based on data known to the agency prior to the beginning of the payment year, that data for the clinician are inaccurate, unusable or otherwise compromised due to circumstances outside the control of the clinician;
11. Beginning with the 2026 MIPS payment year, CMS determines, based on documentation provided to the agency on or before November 1st of the year preceding the relevant MIPS payment year, that data for the clinician are inaccessible or unable to be submitted due to circumstances outside of the control of the clinician because the clinician delegated submission of the data to a third party who did not submit the data in accordance with applicable deadlines.

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Exception for Eligible Clinicians who are not MIPS Eligible Clinicians

This exception applies when the clinician or group:

Is an eligible clinician as defined in 42 CFR § 414.1305 and is not a MIPS eligible clinician as defined in 42 CFR § 414.1310(b)(2), provided they cannot be excluded solely on the basis of being a Qualifying APM Participant or a Partial Qualifying APM Participant.

If the clinicians falls within any of the following defined groups, then this exception does **not** apply:

i. A physician (as defined in section 1861(r) of the Act);
ii. A physician assistant, a nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5) of the Act);
iii. A certified registered nurse anesthetist (as defined in section 1861(bb)(2) of the Act);
iv. A physical therapist or occupational therapist;
v. A qualified speech-language pathologist;
vi. A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act);
vii. A clinical psychologist (as defined by the Secretary for purposes of section 1861(ii) of the Act);
viii. A registered dietician or nutrition professional; and
ix. A group that includes such clinicians.
x. A clinical social worker (as defined in section 1861(hh)(1) of the Act);
xi. A certified nurse midwife (as defined in section 1861(gg)(2) of the Act); and
xii. A group that includes such clinicians.

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Exceptions Requiring Applications

Several Exceptions require approval of an application to CMS. These applications are due no later than December 31, 2025. CMS has recently provided guidance on how to reconcile the Compliance deadline for REACH with the deadline for applications for these exceptions.

Many of the possible exceptions require approval of an application before the exception can be claimed.

If your exception is approved, the points allocated to the Promoting Interoperability performance category will be redistributed to another performance category.

For purposes of the Shared Savings Program and ACO REACH Models, this approval also covers the requirement for the Participant to utilize CEHRT.
It is important to note that the application isn't available to APM Entities.

Your Participants will have to complete the application themselves, though your ACO can help them understand that process.

Application Process

The Participant will need a HCQIS Access Roles and Profile (HARP) account to submit the application. (For more information on how to obtain a HARP account, refer to the Register for a HARP Account document in the QPP Access User Guide.)

Once signed into the QPP website with your HARP credential, select "Exceptions Application" on the left-hand navigation, then "Promoting Interoperability Hardship".

The application deadline is 8 p.m. Eastern on December 31, 2025.

What this means for ACOs

- If an application is required, it must be submitted by December 31, 2025. However, the ACO must be able to attest that an application has been submitted by October 1st. CMS has confirmed that an ACO will be considered to be compliant while groups await approval of the application. However, the ACO must prepared to take quick action to come into compliance if a denial is received.
- ACOs must indicate whether each Participant is utilizing CEHRT or an exception no later than October 1st in REACH (no specific date has been provided for the SSP, though many are utilizing the same October 1st deadline). Any Participants not utilizing a CEHRT or an exception should be terminated from the ACO prior to that date.
- In the June 24th REACH Newsletter, CMS noted that if a Participant has applied for an exception that is sufficient for purposes of October 1st compliance deadline.
- CMS has previously stated that the ACO is not required to submit documentation proving compliance with any of the exceptions but must be able to provide documentation in the event of an audit.
- Each ACO must decide their level of risk tolerance.

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