Participation Criteria for the Quality Payment Program

May 22, 2017

Q&A Session Information

- The speakers will answer as many questions as time allows at the end of the presentation.
- If your question is not answered during the webinar, please contact the Quality Payment Program Service Center at qpp@cms.hhs.gov or 1-866-288-8292.

Please note: questions will be taken via phone. The Q&A chat box is meant for technical issues only.

Introduction

Adam Richards
Health Insurance Specialist
Division of ESRD, Population and Community Health
Center for Clinical Standards & Quality (CCSQ)

Icebreaker

Prior to receiving the Clinician Participation Letter from CMS, how much did you know about the Quality Payment Program?

The Quality Payment Program

Clinicians have two tracks from which to choose:

MIPS

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

OR

Advanced APMs

Advanced Alternative Payment Models (APMs)

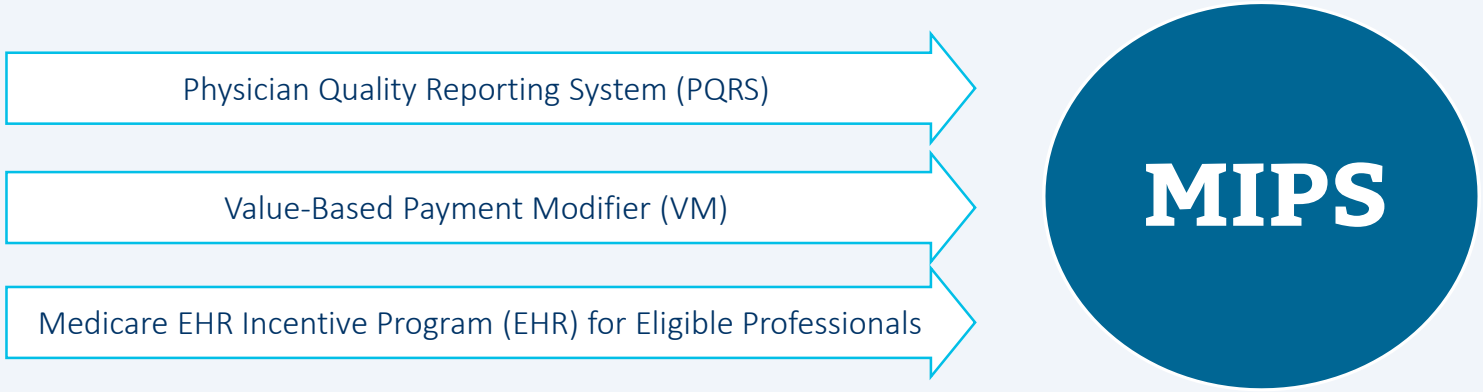
If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

MIPS Basics for the 2017 Transition Year

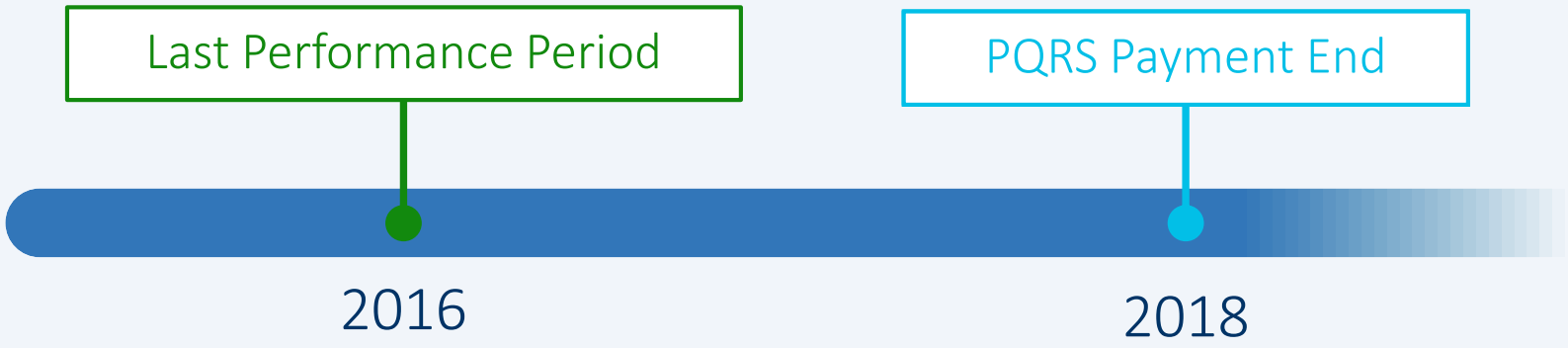
What Do I Need To Know?

The Merit-based Incentive Payment System

Combines legacy programs into a single, improved program



Example of the Legacy Program Phase Out for PQRS



What is the Merit-based Incentive Payment System?

Performance Categories

Quality

Cost

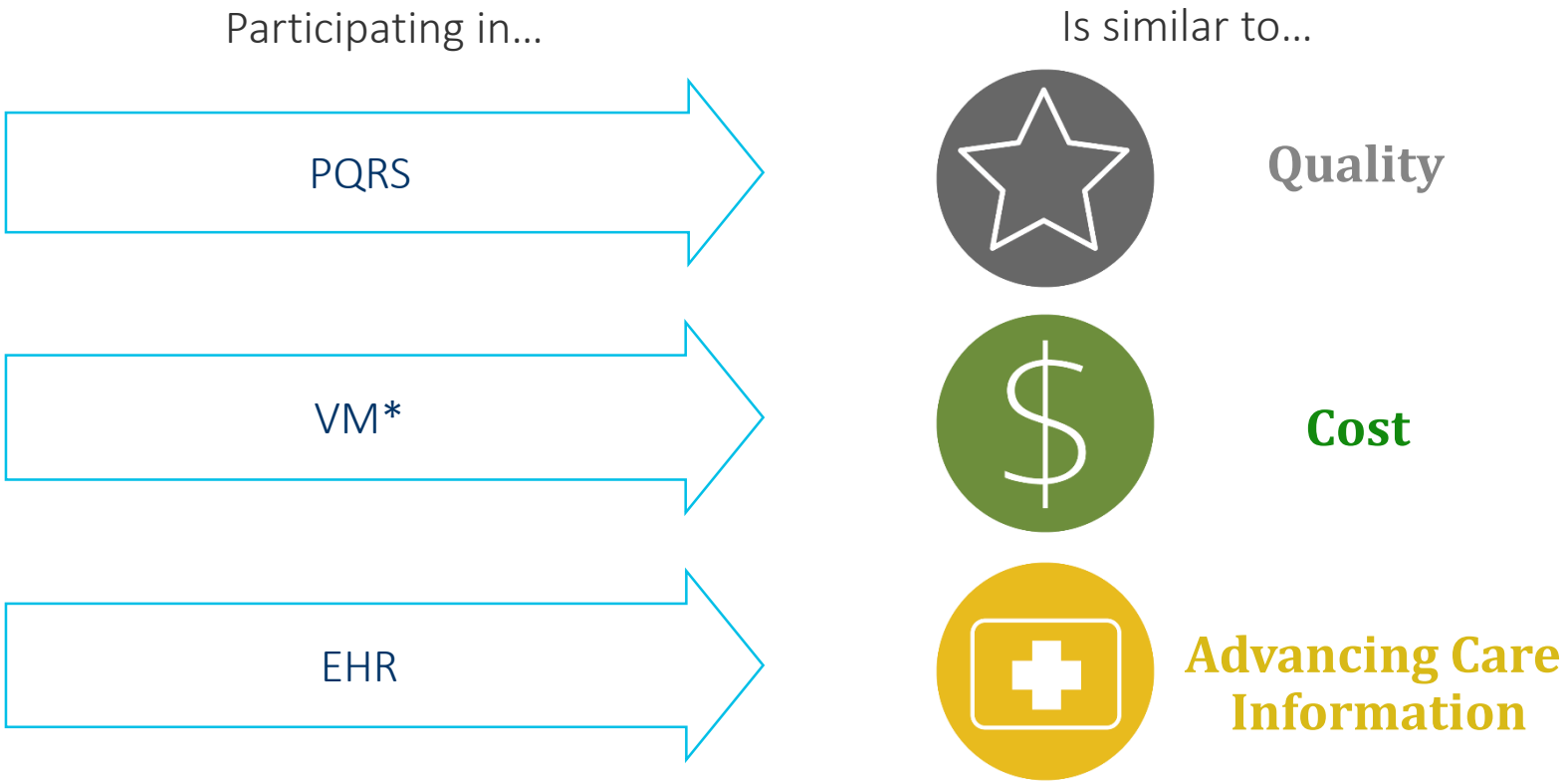
Improvement Activities

Advancing Care Information

- Comprised of four performance categories.
- Provides MIPS eligible clinician types included in the 2017 Transition Year with the flexibility to choose the activities and measures that are most meaningful to their practice.

What is the Merit-based Incentive Payment System?

A visualization of how the legacy programs streamline into the MIPS performance categories:



*Also includes elements of the PQRS quality data

The Merit-based Incentive Payment System

You Have Asked: *"How will these changes impact the adjustments that I am expecting from the legacy programs?"*

- You will still receive your expected adjustments. Here's how:
  - **For PQRS**: Payment adjustments occur after a PQRS program year. Even as MIPS is implemented, clinicians may still see 2018 payment adjustments based on the 2016 PQRS program year.
  - **For Value Modifier**: Positive or negative adjustments will be applied in 2018 based on quality and cost performance in 2016.
  - **For EHR Incentive Program**: The submission deadline for returning providers was March 13, 2017. The Medicare payment adjustments for 2018 will be based on EHR Incentive Program participation in 2016.

Special Note: Medicare EHR Incentive Program

First-time Eligible Professionals (EPs) have until October 1st of their first year to attest and avoid payment adjustments in the subsequent year.

"So what?"

- EPs who are first-first time participants in 2017 have until October 1, 2017 to attest to avoid the 2018 payment adjustment.

However…

- CMS is offering a one-time significant hardship exception to the EHR Incentive Program 2018 payment adjustment.

Special Note: Medicare EHR Incentive Program

Hardship Exception:

- A first-time EP may apply for the exception if:
  - The EP is a first-time participant in the EHR Incentive Program in 2017 **and** intends to participate in the EHR Incentive Program in 2017; and
  - The EP is transitioning to MIPS for the 2017 performance period; and
  - The EP intends to report on measures specified for the Advancing Care Information performance category under MIPS in 2017 (i.e. the Base measures, at minimum).
- Exception Form: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html

Participation Basics for MIPS in the 2017 Transition Year

What Do I Need To Know?

MIPS Participation Basics

As a refresher…

- TIN - Tax Identification Number
  - Used by the Internal Revenue Service (IRS) to identify an entity, such as a group medical practice, that is subject to federal taxes.

- NPI – National Provider Identifier
  - 10-digit numeric identifier for individual clinicians.

- TIN/NPI
  - Identifies the individual clinician and the entity/group practice through which the clinician provides services and pays taxes.

MIPS Participation Basics

In the 2017 Transition Year, you can participate in MIPS:

- As an individual;
- As a group; or
- In an Alternative Payment Model.

Participating in MIPS as an Individual in the 2017 Transition Year

What Do I Need to Know?

Lisa Marie Gomez
Health Insurance Specialist
Division of Electronic and Clinical Quality (DECQ)
Center for Clinical Standards & Quality (CCSQ)

Participation Basics

Must be a MIPS eligible clinician type billing more than $30,000 a year in Medicare Part B allowed charges **AND** providing care for more than 100 Medicare patients a year.

MIPS eligible clinician types include:

Physicians	Physician Assistants	Nurse Practitioners	Clinical Nurse Specialists	Certified Registered Nurse Anesthetists

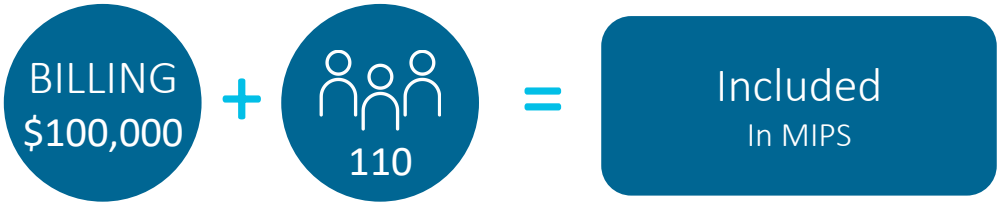
Participation Basics

- The definition of **Physicians** include:
  - Doctors of Medicine
  - Doctors of Osteopathy (including Osteopathic Practitioners)
  - Doctors of Dental Surgery
  - Doctors of Dental Medicine
  - Doctors of Podiatric Medicine
  - Doctors of Optometry
  - Chiropractors
    - With respect to certain specified treatment, a Doctor of Chiropractic legally authorized to practice by a State in which he/she performs this function.

Participation Example: Individual Level

Dr. "A." a M.D.:

- Is a MIPS eligible-clinician type
- Billed $100,000 in Medicare Part B allowed charges
- Saw 110 patients



"So what?" - Dr. A. should actively participate in MIPS during the Transition Year to avoid a **4% reduction** in Medicare Part B payments in 2019 and possibly earn a positive adjustment.

Remember: To participate

Determining Participation for the Transition Year

1. CMS verifies that you meet the definition of a MIPS eligible clinician type.

Then…

2. CMS reviews your historical Medicare Part B claims data from **9/1/15 to 8/31/16** to make the initial determination.
   - "So what?" - If you are determined to be exempt during this review, you will remain exempt for the entire Transition Year.

Later…

3. CMS conducts a second determination on performance period Medicare Part B claims data from **9/1/16 to 8/31/17**.
   - "So what?" -
     - If you were included in the first determination, you may be reclassified as exempt for the Transition Year during the second determination.
     - If you were initially exempt and later found to have claims/patients exceeding the low-volume threshold, you are still exempt.

If You Are Included

- You should actively participate in the Transition Year to receive a neutral adjustment and possibly earn a positive payment adjustment.
- **Not participating** will result in a **-4%** downward payment adjustment.

Who is Exempt from MIPS?

Clinicians who are:

Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to $30,000 a year

OR

- See 100 or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs

- Receive 25% of their Medicare payments

OR

- See 20% of their Medicare patients through an Advanced APM

Exempt Example: Individual Level

Dr. "B." a D.O.:

- Is a MIPS eligible-clinician type
- Billed $100,000 in Medicare Part B allowed charges
- Saw 80 patients

"So what?" - Dr. B. would be exempt from MIPS due to seeing less than 100 patients.

Remember: To participate

If You Are Exempt

- You may choose to voluntarily submit quality data to CMS to prepare for future participation, but you will not qualify for a payment adjustment based on your 2017 performance.
- Voluntarily participating will help you hit the ground running when you are eligible for payment adjustments in future years.

Participating in MIPS as a Group in the 2017 Transition Year

What Do I Need to Know?

Participation at the Group Level

You Have Asked: *"Does the $30,000 in Medicare Part B allowed charges **AND** 100 Medicare Part B patients also apply at the group level if my practice chooses group reporting?"*

Yes. For Transition Year 2017, the low-volume threshold for MIPS also applies at the group level.

"So what?" – The low-volume threshold exclusion is based on both the individual (TIN/NPI) and group (TIN) status. For group-level reporting, a group (as a whole) is assessed to determine if it exceeds the low-volume threshold.

Participation at the Group Level: Example

OPTIONS

Individually
(Assessed at the TIN/NPI Level)

Dr. "A."

- Billed $100,000
- Saw 110 Patients

Included in MIPS

Dr. "B."

- Billed $100,000
- Saw 80 Patients

Exempt from MIPS

Nurse Practitioner

- Billed $50,000
- Saw 40 Patients

Exempt from MIPS

Group
(Assessed at the TIN Level)

As a Group
(Dr. A., Dr. B., NP)

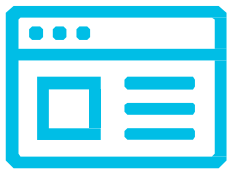
- Billed $250,000
- Saw 230 Patients

ALL Included in MIPS

Remember: To participate BILLING > $30,000 **AND** > 100

Participation at the Group Level

Registration is required for MIPS eligible clinician types participating as a group that wish to report via:



Web Interface

CAHPS for MIPS survey

- *Group registration **closes** on June 30, 2017.*

Otherwise, clinicians do not need to register their group with CMS.

Participating in MIPS: Special Rules and Considerations

What Do I Need to Know?

Participation for Clinicians in Specific Facilities

- Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC)
  - Clinicians billing under the RHC or FQHC payment methodologies **are not** subject to the MIPS payment adjustment.

However…

  - Clinicians in a RHC or FQHC billing under the Physician Fee Schedule (PFS) and who exceed the low-volume threshold **are** required to participate in MIPS and are subject to a payment adjustment.
    - *Please note*: MIPS eligible clinician types who do not exceed the low-volume threshold will be **exempt** from MIPS.

Participation for Clinicians in Specific Facilities

- Critical Access Hospitals (CAH)

1 For MIPS eligible clinician types practicing in Method I:

- MIPS payment adjustment would apply to payments made for items and services that are Medicare Part B charges billed by the MIPS clinicians.
- Payment adjustment would not apply to the facility payment to the CAH itself.

2 For MIPS eligible clinician types practicing in Method II (who assigned their billing rights to the CAH):

- MIPS payment adjustment would apply to the Method II CAH payments

3 For MIPS eligible clinician types practicing in Method II (who have not assigned their billing rights to the CAH):

- MIPS payment adjustment would apply similar to Method I CAHs.

Participation for Clinicians in Specific Facilities

- Hospital-based
  - Clinicians are considered hospital-based if they provide 75% or more of their services in an:
    - Inpatient Hospital;
    - On-campus Outpatient Hospital; or
    - Emergency Room.
  - Hospital-based clinicians are subject to MIPS if they exceed the low-volume threshold and should report the Quality and Improvement Activities performance categories.
    - Hospital-based MIPS eligible clinician types qualify for an automatic reweighting of the **Advancing Care Information** performance category to zero. *However*, they can still choose to report if they would like, and, if data is submitted, CMS will score their performance and weight their Advancing Care Information performance accordingly.

Participation for Clinicians in Specific Facilities

You Have Asked: *"Does MIPS apply to me if I have an employment contract with a hospital or healthcare system?"*

- Yes, MIPS applies to you if the Medicare Part B services that you furnish and are billed on your behalf by another entity, such as a hospital or health system, meet the participation criteria.

Remember: To participate 

Participation for Non-Patient Facing Clinicians

- Non-patient facing clinicians are included in MIPS as long as they exceed the low-volume threshold, are not newly enrolled, and are not a Qualifying APM Participant (QP) or Partial QP that elects not to report data to MIPS.
- An individual MIPS eligible clinician type is considered to be non-patient facing if the clinician is below the threshold of ≤ 100 patient facing encounters in a designated period.
- A group is non-patient facing if >75% of clinicians billing under the group's TIN during a performance period are labeled as non-patient facing.
- There are more flexible reporting requirements for non-patient facing clinicians.

Non-Patient Facing Clinicians: Examples

- Pathologists who advise on appropriate testing and interpret/diagnose the changes caused by disease in tissues and body fluids.

- Radiologists who primarily provide consultative support to a referring physician or provide image interpretation.

- Nuclear Medicine Physicians who play an indirect role in patient care.

- Anesthesiologists who are primarily providing supervision oversight to Certified Registered Nurse Anesthetists.

Participation for Clinicians in Small Practices, Rural Areas, and Health Professional Shortage Areas (HPSAs)

Special rules exist for the **Improvement Activities** performance category under MIPS for:

- MIPS eligible clinician types in practices with 15 or fewer clinicians and solo practitioners;
- MIPS eligible clinician types in designated rural areas; and
- MIPS eligible clinician types working in HPSAs.

The **points** for both medium-weight and high-weight activities are doubled. This means:

- Medium-weight = 20 points; and
- High-weight = 40 points.

Participation with a Type 2 National Provider Identifier (NPI)

You Have Asked: *"I have a Type 2 NPI. Do I need to participate in MIPS?"*

- Only MIPS eligible clinician types with a Type 1 NPI need to participate in MIPS during the Transition Year.
- Type 2 NPIs, such as a hospital, home health agency, lab, or DME supplier, would not participate.

However…

- If you have both a Type 1 and 2 NPI **AND** exceed the low volume threshold, you will need to participate in MIPS.

Participating in MIPS APMs in the 2017 Transition Year

What Do I Need to Know?

Benjamin Chin
Health Policy Analyst
Center for Medicare & Medicaid Innovation (CMMI)

Participation in MIPS APMs

- Applies to MIPS eligible clinician types who participate in certain Alternative Payment Models (APMs).
- Participants receive special MIPS scoring under the APM Scoring Standard.
- Must be participating in the MIPS APM on **at least one** of the following snapshot dates:

- If you are in a MIPS APM – this is the way you are participating in MIPS.
  - Otherwise, a MIPS eligible clinician type must report to MIPS under the standard MIPS methods.

Participation in MIPS APMs

You Have Asked: *"How does the low-volume threshold apply to MIPS clinicians in MIPS APMs?"*

- Similar to the low-volume threshold at the group level.
- Applies to MIPS eligible clinician types practicing as a part of an APM Entity group in a MIPS APM.
- Will be calculated by CMS for the APM Entity group as a collective whole.

Scenarios:

✓ The APM Entity group is required to participate in MIPS if it **exceeds** the low-volume threshold.

× The APM Entity group is exempt from MIPS if it **does not exceed** the low-volume threshold.

Participating in MIPS in the 2017 Transition Year

What Should I Do To Get Started?

Kelly DiNicolo
Senior Technical Advisor
Office of Communications (OC)

Getting Started

Start by: Determining if you are included in MIPS and need to actively participate.

How:

- Review the **Clinician Participation Letter** provided by CMS.
  - This letter will tell you who is included in MIPS and who is exempt.
  - The letters were sent at the TIN level rather than to individual clinicians, so check-in with the representative of your practice group for details.
  - This letter was mailed beginning on April 27, 2017.

Getting Started: Clinician Participation Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Medicare Clinician:

Thank you for your participation in Medicare and the services you provide to people with Medicare. You're an integral part of the dedicated team of clinicians who serve more than 55 million people with Medicare. The clinician-patient relationship is central to our work at the Centers for Medicare & Medicaid Services and we continuously work to reduce the administrative burdens you may face when participating in Medicare programs. During this first year of transition to the Quality Payment Program, we have put together several program options, so you can choose the pace that best meets your practice needs. However, we know we can do more and are committed to diligently working with you over the next year to streamline the process as much as possible. Our goal is to further reduce burdensome requirements so that you can deliver the best possible care to patients. Our doors are open and we look forward to hearing your ideas and receiving your feedback so we can make additional improvements in year two of the Quality Payment Program.

Why am I getting this letter?

You have a practice identified by a taxpayer identification number (TIN) enrolled in Medicare. Starting in 2017, clinicians will participate in the new Quality Payment Program as a group or individually either through the Merit-based Incentive Payment System (MIPS) or participation in an Advanced Alternative Payment Model (APM). **This letter lets you know if your group and the individuals in your group (if those individuals choose to report separately to the program) are exempt from MIPS because of the following:**

- being a low-volume clinician (being below established program thresholds); or
- not being among the categories of clinicians included in the program in the first year.

In addition, you may be exempt from MIPS if you are:

- a new Medicare enrolled clinician; or
- if you are participating in certain Advanced Alternative Payment Models and your participation is sufficient to meet certain thresholds.

Attachment A provides low-volume and non-eligible provider type information in a list for each clinician and group.

MIPS replaces the Physician Quality Reporting System (PQRS), Value Modifier (VM) and the Medicare EHR Incentive Program for eligible clinicians who provide items and services under Medicare Part B. The Quality Payment Program will provide new tools and resources to help you give your patients the best possible, highest-value care. Even better, you could receive positive payment adjustments based on your participation, performance, and engaging in improvement activities. Clinicians who practice under multiple TINs will be notified at the TIN level of their eligibility, and may have different eligibilities for each TIN/practice.

This is the first year of this new program. Based on stakeholder feedback, we have made it much easier to participate in the program from the start. We reduced the number of proposed requirements and created a variety of timelines, so you can pick when you want to start and your pace of participation.

What do I need to do?

Review Attachment A. Determine whether you plan to participate as a group or if clinicians within your group will participate individually. If you participate in an Alternative Payment Model (APM), reach out to your model's support inbox to learn more information about additional support that is available.

Let the clinicians assigned to your TIN know if they're included in MIPS or exempt from MIPS if individual clinician participation is chosen as the method of participation.

- **If included in MIPS, the clinician:**
  - Must participate to potentially earn an upward adjustment and avoid a negative adjustment to their Medicare Part B payments.
  - Can participate as an individual or as part of their group.
  - Can pick the pace of their participation for the first performance period. If they're ready, they can collect performance data beginning with services that were furnished beginning on January 1, 2017. Clinicians can also choose to start anytime between January 1 and October 2, 2017.
  - Must submit any MIPS data to Medicare no later than March 31, 2018 to qualify for a positive or neutral payment adjustment, which will affect their 2019 Medicare Part B payments, and avoid up to a 4% negative payment adjustment in 2019.

Getting Started: Clinician Participation Letter

- **If the clinician is not included in MIPS, the clinician:**
  - Won't be subject to a positive or negative Medicare Part B payment adjustment in 2019 under MIPS.
  - No further action is required unless your TIN decides to participate as a group and is above one of the low volume thresholds.
  - May choose to voluntarily submit data individually to Medicare to learn, to obtain feedback on quality measures, and to prepare in the event MIPS is expanded in the future. Clinicians who submit data voluntarily will not be subject to a positive or negative payment adjustment.

- **If the clinician is a participant in an Advanced APM, the clinician:**
  - Should determine and confirm participation in the Advanced APM (visit **http://go.cms.gov/APMlist** to see an up to date list of Advanced APMs).
  - Should continue to fulfill the participation requirements of the Advanced APM. The Quality Payment Program does NOT change how any particular Advanced APM rewards value or operates, and Advanced APMs have their own quality reporting and participation requirements.
  - Should know that there are special benefits for those who meet threshold levels of participation in an Advanced APM for a year. These benefits include exemption from the MIPS reporting and payment adjustments, and a 5% lump sum APM incentive payment, if CMS determines the clinician is a Qualifying APM Participant (QP) in any one of three determinations conducted throughout a performance year. A clinician can become a QP by participating in an Advanced APM and reaching the thresholds for sufficient Medicare Part B payments or Medicare patients through the Advanced APM.
  - Should know that eligible clinicians participating in Advanced APMs who do not meet the threshold to be QPs may qualify as a Partial Qualifying APM Participant (Partial QP) if they meet certain minimum thresholds of Medicare Part B payments or Medicare patients through the Advanced APM. Partial QPs can elect to report to MIPS and be subject to MIPS payment adjustments, or not to report to MIPS, and be excluded from MIPS payment adjustments.
  - Should know that MIPS eligible clinicians participating in Advanced APMs who do not meet the threshold to be QPs or Partial QPs will be subject to MIPS. However, they may receive special MIPS scoring considerations.
  - Should consider the impact under the Quality Payment Program if the clinician wants to exit the Advanced APM during the year, as exiting early could nullify these benefits.

If your TIN would like to report MIPS data as a group, the group will get one MIPS final score based on the group's performance. You should plan your participation and let the eligible clinicians assigned to your TIN know what they need to do for your group to successfully participate in MIPS. If you participate as a group, you'll be assessed as a group across all MIPS performance categories.

Get help & more information

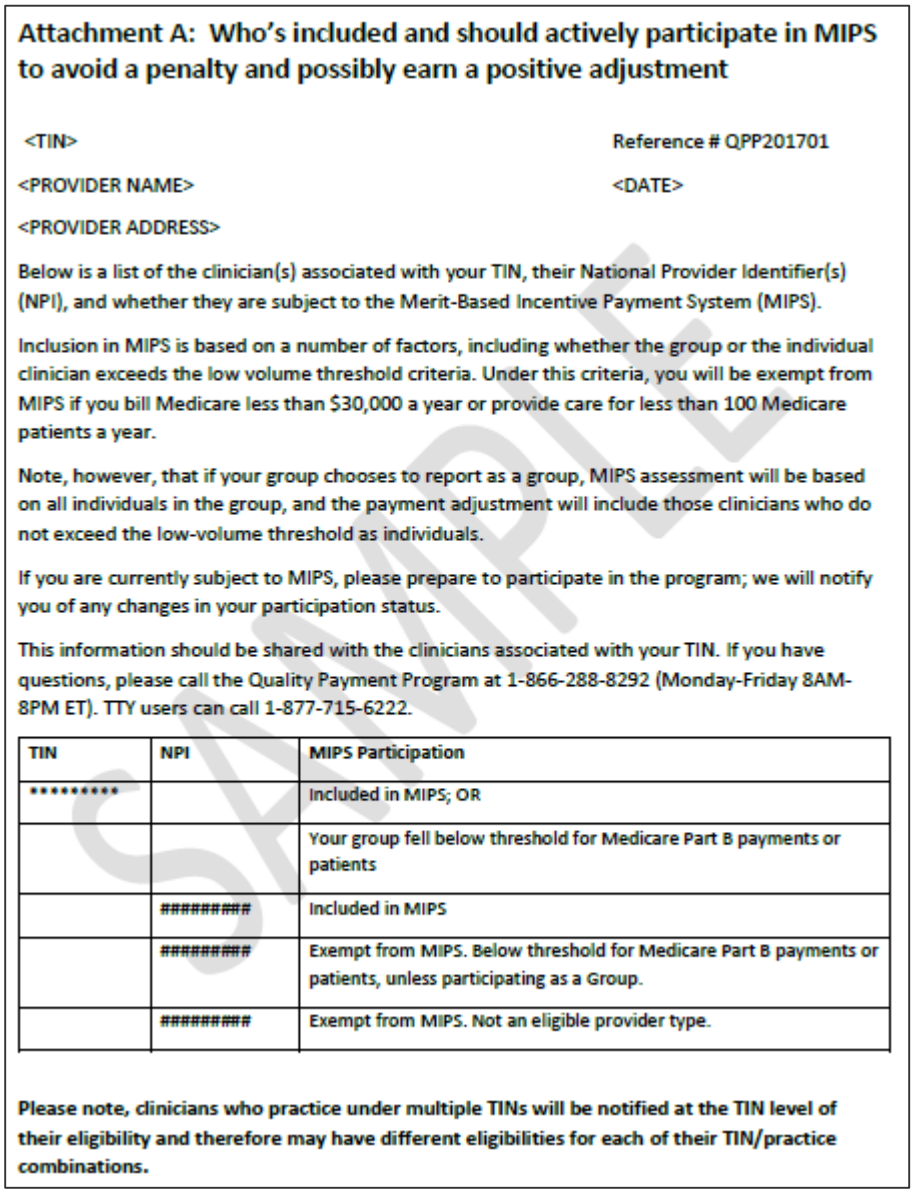
Attachment B has further guidance, including helpful questions and answers about the Quality Payment Program. If you need more help, you can also:

- **Visit** qpp.cms.gov for helpful resources or
- **Contact the** Quality Payment Program at QPP@cms.hhs.gov or **1-866-288-8292** (Monday-Friday 8AM-8PM ET) to find local help in your community. **TTY** users can call **1-877-715-6222**.

Getting Started: Clinician Participation Letter

Attachment A: What is this?

- Explains who is included in MIPS and should actively participate.
  - Identifies included vs. exempt status.
- Lists the NPIs associated with the TIN.
- Provides contact information for the Quality Payment Program for direct support.



Attachment A: Who's included and should actively participate in MIPS to avoid a penalty and possibly earn a positive adjustment

<TIN> Reference # QPP201701

<PROVIDER NAME> <DATE>

<PROVIDER ADDRESS>

Below is a list of the clinician(s) associated with your TIN, their National Provider Identifier(s) (NPI), and whether they are subject to the Merit-Based Incentive Payment System (MIPS).

Inclusion in MIPS is based on a number of factors, including whether the group or the individual clinician exceeds the low volume threshold criteria. Under this criteria, you will be exempt from MIPS if you bill Medicare less than $30,000 a year or provide care for less than 100 Medicare patients a year.

Note, however, that if your group chooses to report as a group, MIPS assessment will be based on all individuals in the group, and the payment adjustment will include those clinicians who do not exceed the low-volume threshold as individuals.

If you are currently subject to MIPS, please prepare to participate in the program; we will notify you of any changes in your participation status.

This information should be shared with the clinicians associated with your TIN. If you have questions, please call the Quality Payment Program at 1-866-288-8292 (Monday-Friday 8AM-8PM ET). TTY users can call 1-877-715-6222.

TIN	NPI	MIPS Participation
*********		Included in MIPS; OR
		Your group fell below threshold for Medicare Part B payments or patients
	#########	Included in MIPS
	#########	Exempt from MIPS. Below threshold for Medicare Part B payments or patients, unless participating as a Group.
	#########	Exempt from MIPS. Not an eligible provider type.

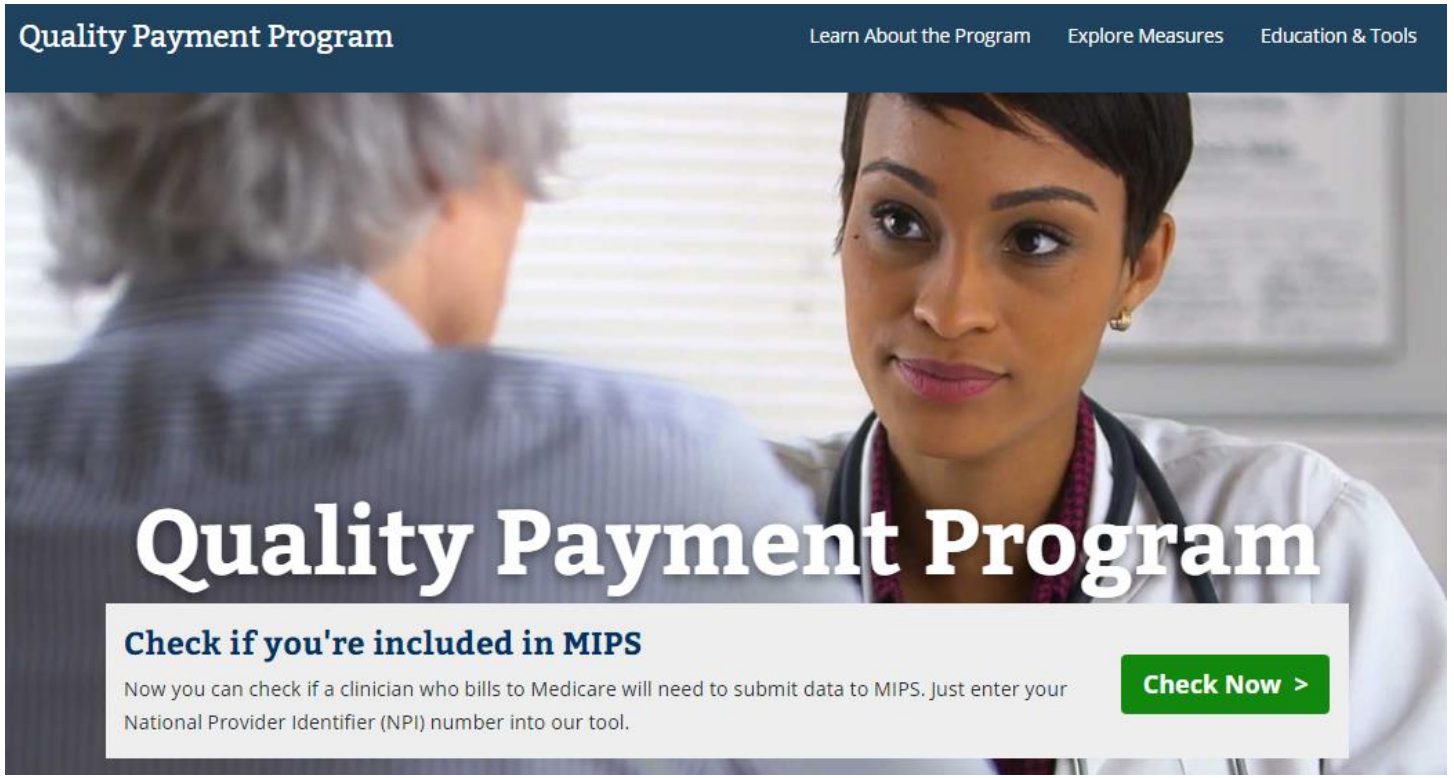
Please note, clinicians who practice under multiple TINs will be notified at the TIN level of their eligibility and therefore may have different eligibilities for each of their TIN/practice combinations.

SAMPLE

Getting Started: MIPS Participation Look-Up Tool

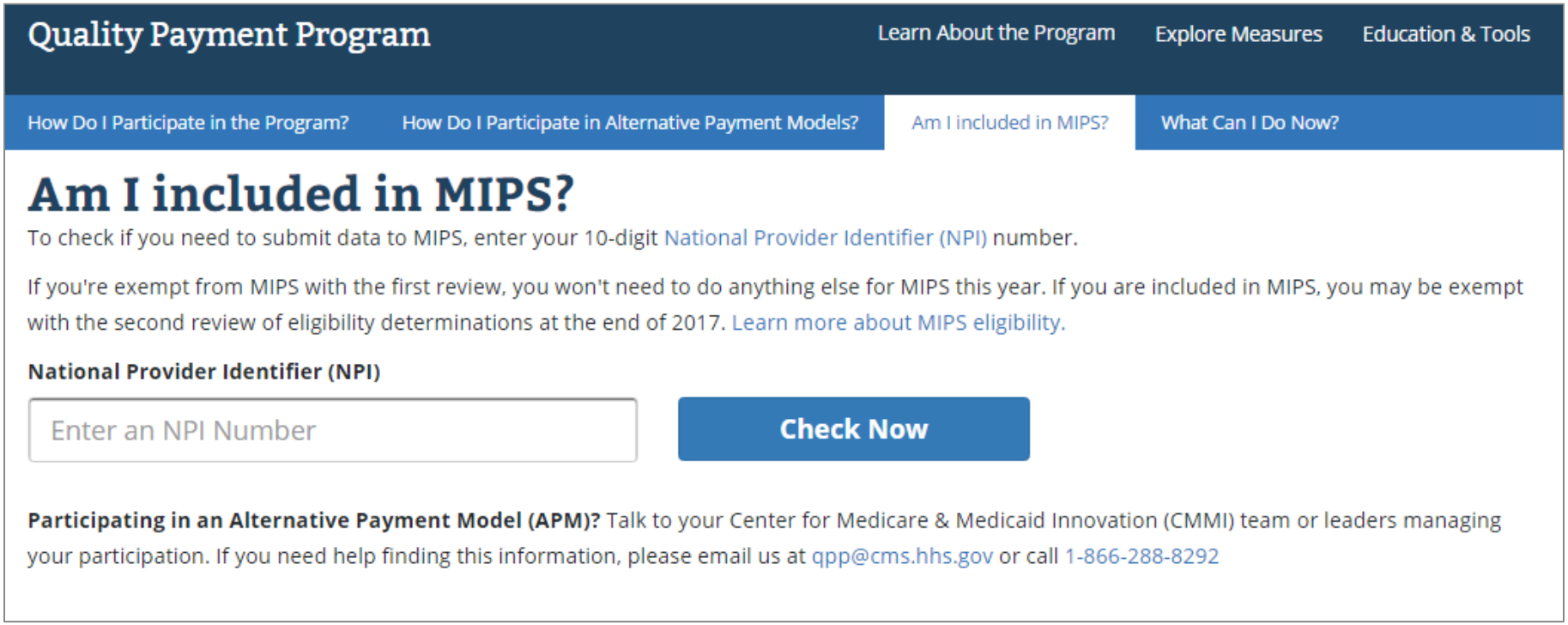
You could also check your participation status by:

- Using the MIPS Participation Look-up Tool on **qpp.cms.gov**.



Getting Started: MIPS Participation Look-Up Tool

- Enter your NPI into the search field and select “Check Now.”



Getting Started: MIPS Participation Look-Up Tool - Included

Am I included in MIPS?

To check if you need to submit data to MIPS, enter your 10-digit National Provider Identifier (NPI) number.

If you're exempt from MIPS with the first review, you won't need to do anything else for MIPS this year. If you are included in MIPS, you may be exempt with the second review of eligibility determinations at the end of 2017. Learn more about MIPS eligibility.

National Provider Identifier (NPI)

XXXXXXXXXX

Check Now

Included in MIPS

Jane Sample, MD **must submit data to MIPS by March 2018.** This clinician will need to report as an individual or with a group.

What Can I Do Now?

Show Less

Clinician Summary

Clinician Name	NPI	Provider Type	Associated TINs	Enrolled in Medicare before Jan 1, 2017
Jane Sample, MD	XXXXXXXXXX	Doctor of Medicine	1	Yes

Practice Details

Practice Name	Address	If clinician reports as individual	If clinician reports with group *
Medical Group A	1234 MAIN STREET SUITE 100 BALTIMORE, MD 212447631	**Included in MIPS.** This clinician has billed Medicare for more than $30,000 and has provided care for more than 100 patients at this practice.	**Included in MIPS.** This practice has billed Medicare for more than $30,000 and has provided care for more than 100 patients.

Getting Started: MIPS Participation Look-up Tool - Exempt

Am I included in MIPS?

To check if you need to submit data to MIPS, enter your 10-digit National Provider Identifier (NPI) number.

If you're exempt from MIPS with the first review, you won't need to do anything else for MIPS this year. If you are included in MIPS, you may be exempt with the second review of eligibility determinations at the end of 2017. Learn more about MIPS eligibility.

National Provider Identifier (NPI)

XXXXXXXXXX

Check Now

Exempt from MIPS Jen Doe, CNM is **not required to submit data to MIPS for 2017**

Show Less

Clinician Summary

Clinician Name	NPI	Provider Type	Associated TINs	Enrolled in Medicare before Jan 1, 2017
Jen Doe, CNM	XXXXXXXXXX	Certified Nurse-Midwife	1	Yes

Practice Details

Practice Name	Address	If clinician reports as individual	If clinician reports with group *
Medical Group B	1234 NEW STREET BALTIMORE, MD 212447631	**Exempt from MIPS.** This clinician is not an eligible provider type.	**Included in MIPS.** This practice has billed Medicare for more than $30,000 and has provided care for more than 100 patients.

Getting Started

You Have Asked: *"What should I do if I need to participate in MIPS?"*

Tips for Getting Started:

- Prepare to participate by reviewing practice readiness, ability to report, and the **Pick Your Pace** options.
- Choose whether you want to submit data as an **individual** or as a part of a **group**.
- Choose your submission method and verify its capabilities.
- Verify your EHR vendor or registry's capabilities before your chosen reporting period.
- Choose your measures. Visit **qpp.cms.gov** for valuable resources on measure selection, and remember to review your current billing codes and Quality Resource Use Report to help identify measures that best suit your practice.
- Submit your data by **March 31, 2018**. Please note that the submission window will open January 1, 2018.

Advanced APM Participation in the 2017 Transition Year

What Do I Need to Know?

Benjamin Chin
Health Policy Analyst
Center for Medicare & Medicaid Innovation (CMMI)

Advanced Alternative Payment Models

Clinicians and practices can:

- Receive **greater rewards** for taking on some risk related to patient outcomes.

Advanced APMs →  + 

Advanced APM-specific rewards

5% lump sum incentive

"So what?" - It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates extra incentives for a sufficient degree of participation in Advanced APMs.

Participating in Advanced APMs as a Qualifying APM Participant (QP)

Clinicians must become Qualifying APM Participants (QP) to earn Advanced APM rewards.

Qualifying APM Participants are clinicians who have a certain **% of Part B payments for professional services or patients furnished Part B professional services** through an **Advanced APM Entity**.

Beginning in 2021, this threshold % may be reached through a combination of Medicare and other **non-Medicare payer arrangements**, such as private payers and Medicaid.

How do Clinicians become Qualifying APM Participants?—Step 1

1

- ✓ Qualifying APM Participant determinations are made at the Advanced APM Entity level, with certain exceptions:
  - ✓ Individuals participating in multiple Advanced APM Entities, none of which meet the QP threshold as a group, and
  - ✓ Clinicians on an Affiliated Practitioner List when that list is used for the QP determination because there are no clinicians on a Participation List for the Advanced APM Entity. For example, gain sharers in the Comprehensive Care for Joint Replacement Model (Track 1-CEHRT) will be assessed individually.

How do Clinicians become Qualifying APM Participants?—Step 2

2

- ✓ CMS will calculate a percentage "Threshold Score" for each Advanced APM Entity using two methods (payment amount and patient count).
- ✓ Methods are based on Medicare Part B professional services and beneficiaries attributed to an Advanced APM.
- ✓ CMS will use the method that results in a more favorable QP determination for each Advanced APM Entity.

These definitions are used for calculating Threshold Scores under both methods.

Attributed (beneficiaries for whose cost and quality of care the APM Entity is responsible)

Attribution-eligible (all beneficiaries who could potentially be attributed)

How do Clinicians become Qualifying APM Participants?—Step 2

2

✓ The two methods for calculation are Payment Amount Method and Patient Count Method.

Payment Amount Method

$$\frac{\text{\$\$\$ for Part B professional services to attributed beneficiaries}}{\text{\$\$\$ for Part B professional services to attribution-eligible beneficiaries}} = \text{Threshold Score \%}$$

Patient Count Method

$$\frac{\text{\# of attributed beneficiaries given Part B professional services}}{\text{\# of attribution-eligible beneficiaries given Part B professional services}} = \text{Threshold Score \%}$$

How do Clinicians become Qualifying APM Participants?—Step 3

3

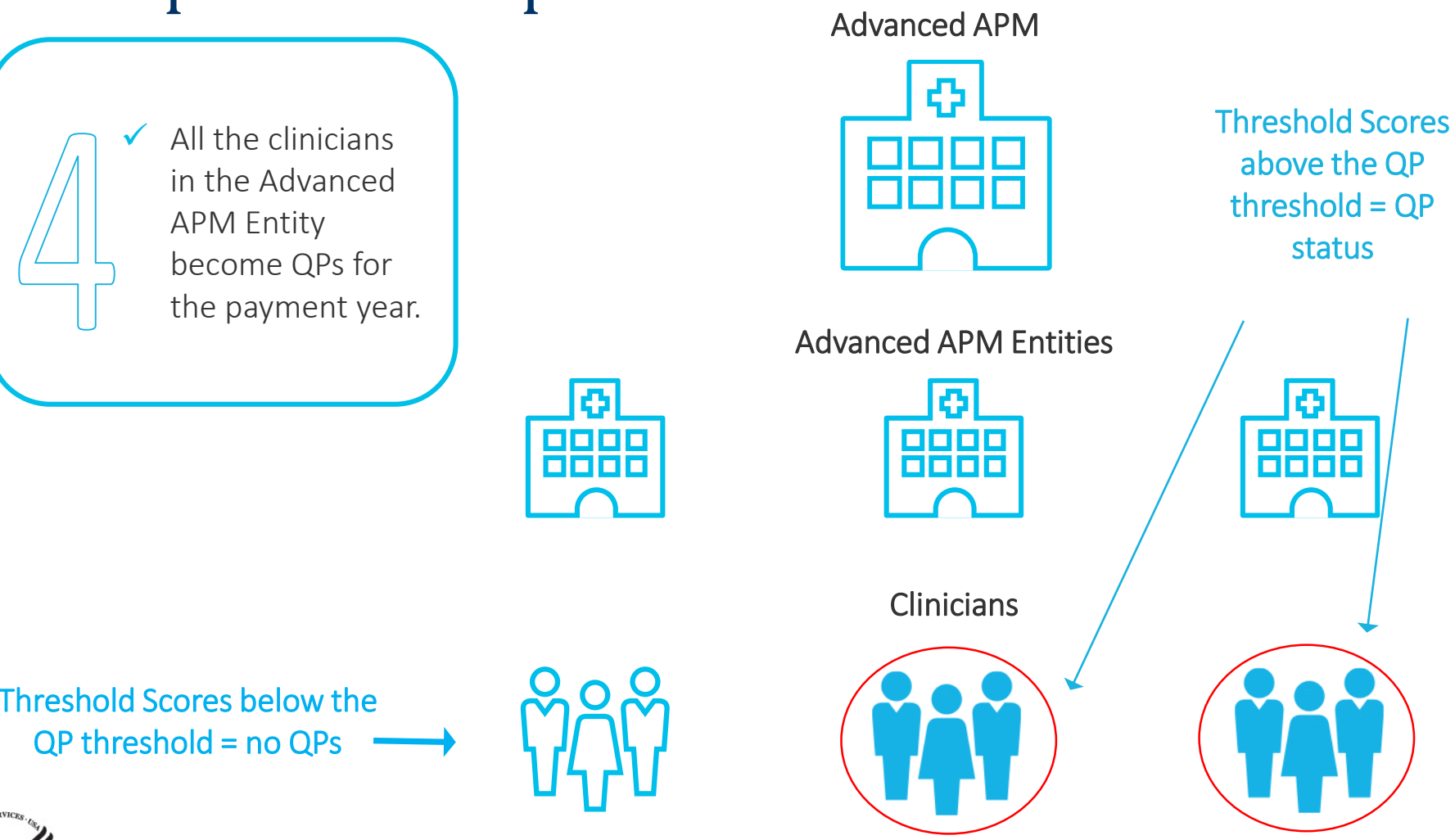
✓ The Threshold Score for each method is compared to the corresponding QP threshold table and CMS takes the better result.

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)						
Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

How do Clinicians become Qualifying APM Participants?—Step 4

4

✓ All the clinicians in the Advanced APM Entity become QPs for the payment year.



How are QPs Determined during the Performance Period?

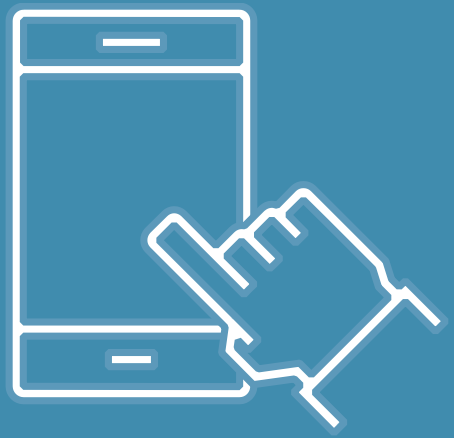
- During the QP Performance Period (January—August), CMS will take three "snapshots" (March 31, June 30, August 31) to determine which clinicians are participating in an Advanced APM and whether they meet the thresholds to become Qualifying APM Participants.
- Reaching the QP threshold at any one of the three QP determinations will result in QP status for the clinicians in the Advanced APM Entity.

What if Clinicians do not meet the QP Payment or Patient Thresholds?

- Clinicians who participate in Advanced APMs, but do not meet the QP threshold, may become "Partial" Qualifying APM Participants (Partial QPs).
- Partial QPs choose whether to participate in MIPS.

Medicare-Only Partial QP Thresholds in Advanced APMs						
Payment Year	2019	2020	2021	2022	2023	2024 and later
Percentage of Payments	20%	20%	40%	40%	50%	50%
Percentage of Patients	10%	10%	25%	25%	35%	35%

What Support is Available?



Adam Richards
Health Insurance Specialist
Division of ESRD, Population and Community Health
Center for Clinical Standards & Quality (CCSQ)

Technical Assistance for Clinicians

CMS has **free** resources and organizations on the ground to provide help to clinicians who are participating in the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISC@TruvenHealth.com for extra assistance.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
  - For more information or for assistance getting connected, contact QPPSURS@IMPAQINT.COM.

LARGE PRACTICES

Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

Q&A Session Information

- Please dial **(866) 452-7887** to ask a question.
- If prompted, use passcode: **23724799**
- The speakers will answer as many questions as time allows.
- If your question is not answered during the webinar, please contact the Quality Payment Program Service Center at qpp@cms.hhs.gov or 1-866-288-8292.
- CMS is also encouraging attendee feedback on other educational methods you find helpful to learn about new concepts.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