Quality Payment
PROGRAM

OVERVIEW OF MIPS FOR SMALL, RURAL, AND UNDERSERVED PRACTICES

July 12, 2017

NHMA

National Hispanic Medical Association

Elena Rios, MD, MSPH, FACP

President & CEO

NHMAmd.org

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NHMA -Who are We?

- Established in 1994 in DC, NHMA is a non-profit 501c6 association representing 50,000 Hispanic physicians in the U.S.

- Mission: to empower Hispanic physicians to improve the health of Hispanic populations with Hispanic medical societies, residents, students and public and private partners.

- Established in 2002, NHMA's foundation, National Hispanic Health Foundation, a non-profit 501c3 foundation for research & education activities – affiliated with NYU Wagner Graduate School of Public Service.

- We serve as a **Resource** to the White House, Congress, Executive Branch and private to lead efforts that improve the health and wellness of Hispanic and other underserved groups.

- Provides executive **Leadership Development** to Hispanic physicians and other health professionals.

- Provides **Networking Opportunities** for career enhancement and growth through national and regional conferences.

NHMA Priorities

- Quality Care and Latino Patients
- Measures from a team approach
- Cultural competence in leadership
- Data analytics for quality in underserved area
- NHMA participates in the Transforming Clinical Practice Initiative with speakers at Fall Region Forums Sept- Nov 2017 & NHMA Annual Conference, Washington DC, 03.22-25.2018

QUALITY PAYMENT PROGRAM

Overview

Adam Richards
Health Insurance Specialist

Disclaimers

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

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Question & Answer (Q&A) Session

Quality Payment PROGRAM

- There will be a Q&A session if time allows. However, CMS must protect the rulemaking process and comply with the Administrative Procedure Act.
- Participants are invited to share initial comments or questions, but only comments formally submitted through the process outlined by the Federal Register will be taken into consideration by CMS.
- See the proposed rule for information on how to submit a comment.

Quality Payment Program

Topics

- Overview of the Quality Payment Program
- Overview of 2017 Participation Requirements
  - Merit-based Incentive Payment System (MIPS)
  - Considerations for Small, Rural, and Underserved Practices
- Changes Proposed for Year Two
- Submitting Comments and Q&A

The Quality Payment Program

Quality Payment PROGRAM

Clinicians have two tracks to choose from:

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.

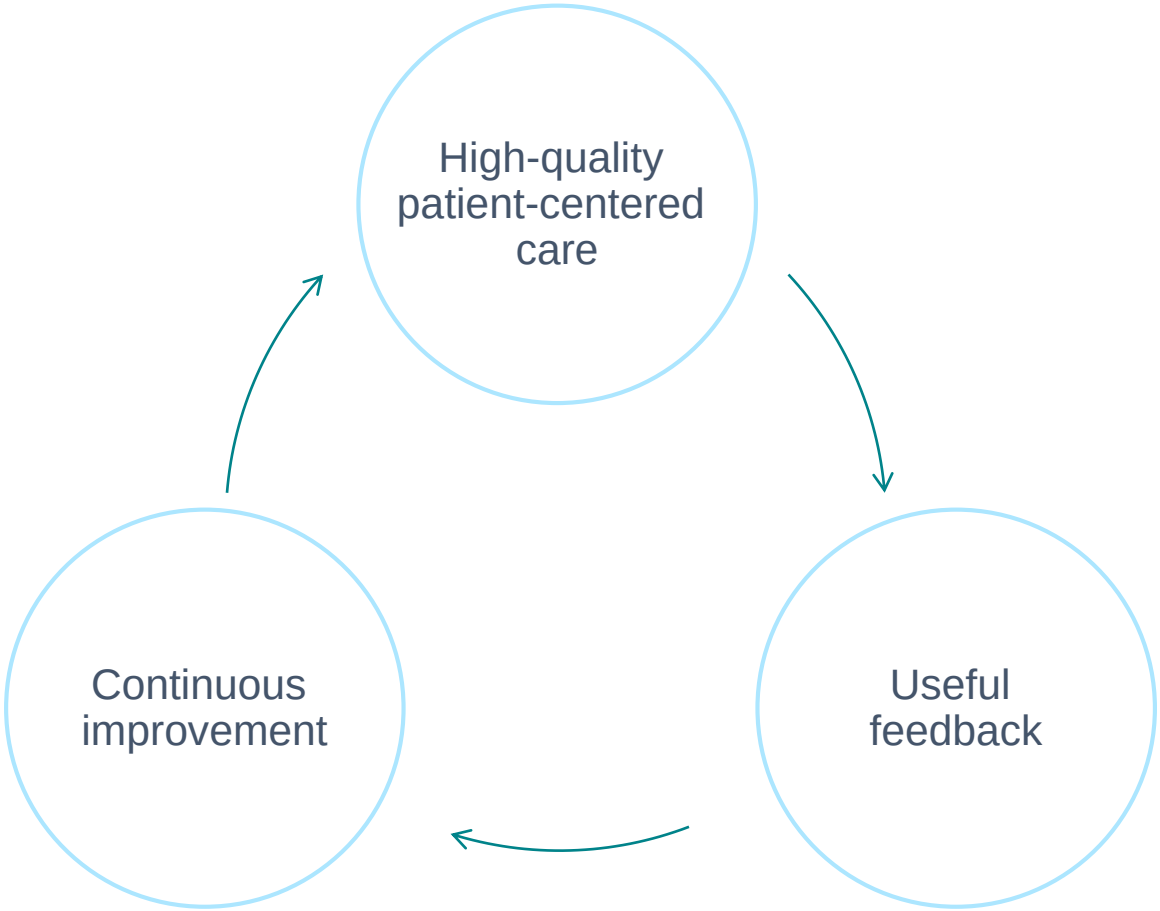
OR

Advanced 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.

Quality Payment Program

Bedrock



Quality Payment Program

Considerations

Quality Payment PROGRAM

- Improve beneficiary outcomes
- Reduce burden on clinicians
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation
- Deliver IT systems capabilities that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov

Quality Payment
PROGRAM

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Basics for the 2017 Transition Year

What is the Merit-based Incentive Payment System?

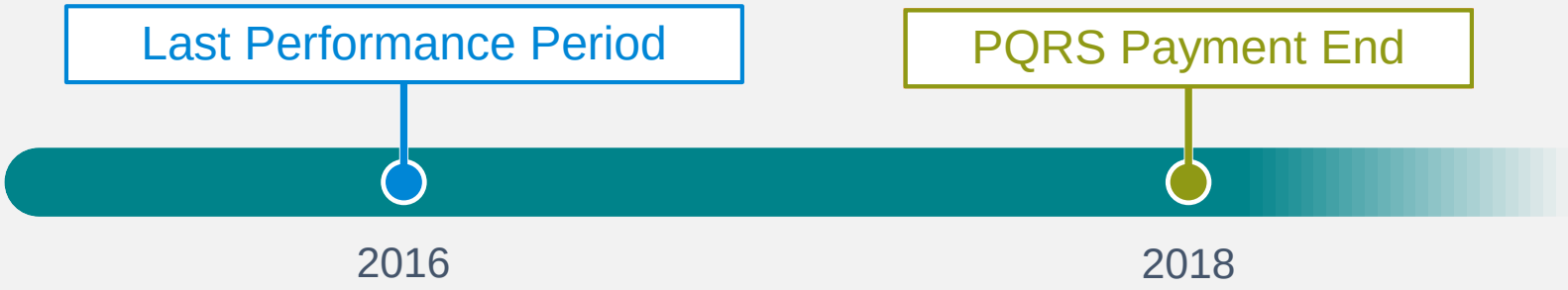
Quality Payment PROGRAM

Combines legacy programs into a single, improved program

- Physician Quality Reporting System (PQRS)
- Value-Based Payment Modifier (VM)
- Medicare EHR Incentive Program (EHR) for Eligible Professionals

MIPS

Example of the Legacy Program Phase Out for PQRS



What is the Merit-based Incentive Payment System?

Quality Payment PROGRAM

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?

Quality Payment PROGRAM

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

Participating in…	Is similar to…
PQRS	 Quality
VM*	 Cost
EHR	 Advancing Care Information

*Also includes elements of the PQRS quality data

The Merit-based Incentive Payment System

Quality Payment PROGRAM

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

Quality Payment 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

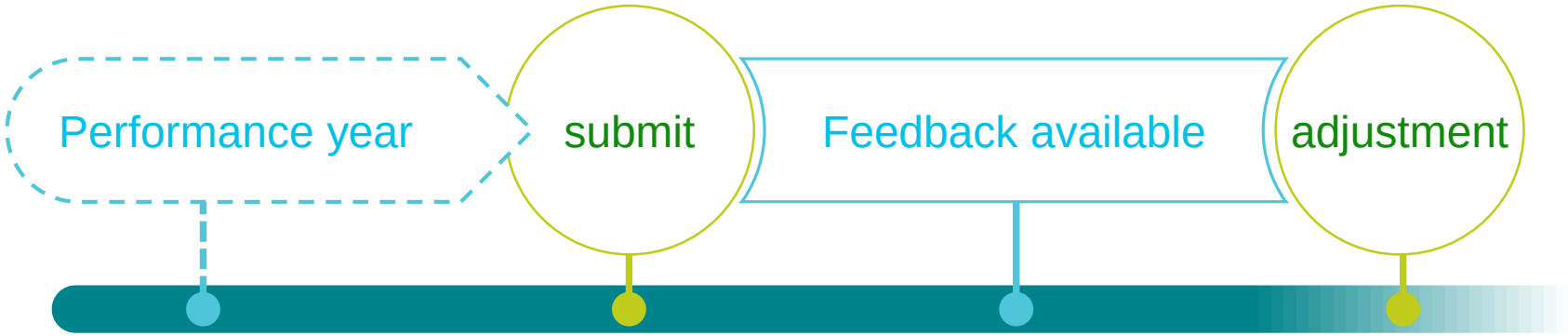
Quality Payment PROGRAM

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

When Does the Merit-based Incentive Payment System Officially Begin?

Quality Payment PROGRAM



2017
Performance Year

- Performance period opens January 1, 2017.
- Closes December 31, 2017.
- Clinicians care for patients and record data during the year.

March 31, 2018
Data Submission

- Deadline for submitting data is March 31, 2018.
- Clinicians are encouraged to submit data early.

Feedback

- CMS provides performance feedback after the data is submitted.
- Clinicians will receive feedback before the start of the payment year.

January 1, 2019
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim begin January 1, 2019.

Quality Payment
PROGRAM

MIPS

Participation Basics for the 2017 Transition Year

Ashby Wolfe, MD, MPP, MPH
Chief Medical Officer, Region IX

Who is Included in MIPS?

Quality Payment PROGRAM

MIPS eligible clinicians 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 clinicians include:

Physicians

Physician Assistants

Nurse Practitioners

Clinical Nurse Specialists

Certified Registered Nurse Anesthetists

Who is Included in MIPS?

Quality Payment PROGRAM

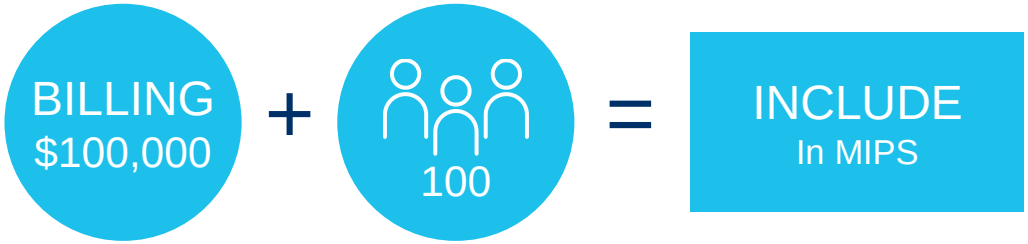
- The definition of **Physicians** include:
  - Doctors of Medicine
  - Doctors of Osteopathy (including Osteopathic Practitioners)
  - Doctors of Dental Surgery
  - Doctors of Dental Medicine
  - Doctors of Podiatric Medicine
  - Doctors of Optometry
  - Chiropractors
    - With respect to certain specified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

Participating at the Individual Level: Example

Quality Payment PROGRAM

Dr. “A.” a M.D.:

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



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

If You Are Included

Quality Payment PROGRAM

- 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?

Quality Payment PROGRAM

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

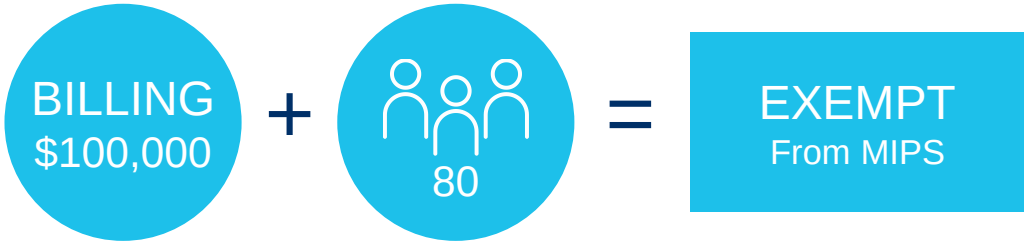
- See 20% of their Medicare patients through an Advanced APM

Exempt Example

Quality Payment PROGRAM

Dr. “B.” is:

- An eligible clinician
- Billed $100,000 in Medicare Part B charges
- Saw 80 patients



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.
- This will help you hit the ground running when you are eligible for payment adjustments in future years.

MIPS

Participation: Special Considerations

Participation for Clinicians in Specific Facilities

Quality Payment PROGRAM

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) are required to participate in MIPS and are subject to a payment adjustment.

Participation for Clinicians in Specific Facilities

Quality Payment PROGRAM

Critical Access Hospitals (CAH)

1

For clinicians 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 eligible clinicians.
- Payment adjustment would not apply to the facility payment to the CAH itself.

2

For clinicians 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 clinicians practicing in Method II (who have not assigned their billing rights to the CAH):

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

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 Non-Patient Facing Clinicians

Quality Payment PROGRAM

- 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 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.

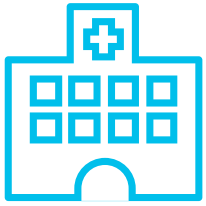
MIPS

Participation Options

Pick Your Pace for Participation for the Transition Year

Quality Payment PROGRAM

Participate in an Advanced Alternative Payment Model



Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

MIPS

TEST

Submit Something

- Submit **some** data after January 1, 2017
- Neutral or small payment adjustment

PARTIAL YEAR

Submit a Partial Year

- Report for 90-day period after January 1, 2017
- Neutral or positive payment adjustment

FULL YEAR

Submit a Full Year

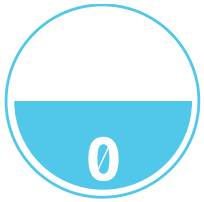
- Fully participate starting January 1, 2017
- Positive payment adjustment

Note: Clinicians do not need to tell CMS which option they intend to pursue.

Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.

MIPS: Choosing to Test for 2017

Quality Payment PROGRAM



Submit Something

- Submit **minimum** amount of 2017 data to Medicare
- **Avoid** a downward adjustment
- Gain familiarity with the program

Minimum Amount of Data

1
Quality
Measure

OR

1
Improvement
Activity

OR

4 or 5*
Required
Advancing Care
Information
Measures

*Depending on CEHRT edition

Partial and Full Year Reporting

Requirements for the Transition Year

Quality Payment PROGRAM

MIPS payment adjustment is based on data submitted.
Clinicians should pick what's best for their practice.

Submit a Partial Year

Partial year participation:

- Submit **90 days** of 2017 data
- Start anytime between January 1, 2017 and October 2, 2017
- May earn a positive payment adjustment
- You can still earn the max adjustment

Submit a Full Year

Full year participation:

- Submit a **full year** of 2017 data
- Is the best way to get the max adjustment
- Gives you the most measures to choose from
- Prepares you the most for the future of the program

MIPS

Reporting and Data Submission Options

Individual vs. Group Reporting

Quality Payment PROGRAM

OPTIONS

1. Individual—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits

2. As a Group
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As an APM Entity

* If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories

Reporting Options Example

Quality Payment PROGRAM

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

Submission Methods

Quality Payment PROGRAM

	Individual	Group
 Quality	• Qualified Clinical Data Registry (QCDR) • Qualified Registry • EHR • Claims	• QCDR • Qualified Registry • EHR • Administrative Claims • CMS Web Interface • CAHPS for MIPS Survey*
 Improvement Activities	• QCDR • Qualified Registry • EHR • Attestation	• QCDR • Qualified Registry • EHR • CMS Web Interface • Attestation
 Advancing Care Information	• QCDR • Qualified Registry • EHR • Attestation	• QCDR • Qualified Registry • EHR • Attestation • CMS Web Interface

*Must be reported via a CMS approved survey vendor together with another submission method for all other Quality measures.

Submission Methods: Helpful Information

Quality Payment PROGRAM

Submission Mechanism	How does it work?
Qualified Clinical Data Registry (QCDR)	A QCDR is a CMS-approved entity that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. Each QCDR typically provides tailored instructions on data submission for MIPS eligible clinicians.
Qualified Registry	A Qualified Registry collects clinical data from a MIPS eligible clinician or group of MIPS eligible clinicians and submits it to CMS on their behalf.
Electronic Health Record (EHR)	MIPS eligible clinicians submit data directly through the use of an EHR system that is considered certified EHR technology (CEHRT). Alternatively, groups may work with a third-party vendor to submit data on their behalf.
Consumer Assessment of Healthcare Providers and System (CAHPS) for MIPS Survey	CMS-approved survey vendor that collects and submits data about the experience of care at the practice on behalf of the group.
CMS Web Interface	A secure internet-based application available to pre-registered groups of clinicians. CMS loads the Web Interface with the group's patients. The group then completes data for the pre-populated patients.
Claims	Clinicians select measures and begin reporting through the routine billing processes.

MIPS

Performance Categories

MIPS Performance Category

Quality

Quality Payment PROGRAM

- **60%** of Final Score in 2017
- 270+ measures available
  - You **select 6** individual measures
    - 1 must be an **Outcome** measure
      OR
    - **High-priority** measure
      - Defined as outcome measures, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination.
  - You may also select specialty-specific set of measures
- ***Keep in mind:***

Replaces PQRS and Quality portion of the Value Modifier	Provides for an easier transition for those who have reporting experience due to familiarity

Quality

Requirements for the Transition Year

Quality Payment PROGRAM

Submit Something

Test means:

- Submitting 1 Quality measure

Submit a Partial Year

Submit a Full Year

Partial and Full means:

- Submitting at least 6 quality measures, including 1 Outcome or 1 High-Priority measure
- 90 days for Partial Year
- 1 year for Full Year

For a full list of measures, please visit
QPP.CMS.GOV

MIPS Performance Category

Cost

Quality Payment PROGRAM

- No reporting requirement; **0%** of Final Score in 2017
- Clinicians assessed on Medicare claims data
- CMS will still provide feedback on how you performed in this category in 2017, but it will not affect your 2019 payments.
- ***Keep in mind:***

Uses measures previously used in the Physician Value-Based Modifier program or reported in the Quality and Resource Use Report (QRUR)	Only the scoring is different

MIPS Performance Category

Improvement Activities

Quality Payment PROGRAM

- **15%** of Final Score in 2017
- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access
- ***Clinicians choose*** from 90+ activities under 9 subcategories:

1. Expanded Practice Access	2. Population Management	3. Care Coordination
4. Beneficiary Engagement	5. Patient Safety and Practice Assessment	6. Participation in an APM
7. Achieving Health Equity	8. Integrating Behavioral and Mental Health	9. Emergency Preparedness and Response

MIPS Performance Category

Improvement Activities

Special consideration for:

Groups with 15 or fewer participants, non-patient facing clinicians, or if you are in a rural or health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days.

Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit.

Participants in certain APMs, such as Shared Savings Program Track 1 or the Oncology Care Model: You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.

Improvement Activities

Requirements for the Transition Year

Quality Payment PROGRAM

Submit Something

Test means:

- Attesting to 1 Improvement Activity
  - Activity can be high or medium weight
  - In most cases, to attest you need to indicate that you have done the activity for 90 days.

Submit a Partial Year

Submit a Full Year

Partial and Full means:

- Attesting to 1 of the following combinations:
  - 2 high-weighted activities
  - 1 high-weighted activity and 2 medium-weighted activities
  - At least 4 medium-weighted activities
- Clinicians with special considerations:
  - 1 high-weighted activity
  - 2 medium-weighted activities

For a full list of measures, please visit
QPP.CMS.GOV

MIPS Performance Category

Advancing Care Information

Quality Payment PROGRAM

- **25%** of Final Score in 2017
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Ends and replaces the Medicare EHR Incentive Program (also known as Medicare Meaningful Use)
- Greater flexibility in choosing measures
- In 2017, there are ***2 measure sets for reporting to choose from based on EHR*** edition:

Advancing Care Information Objectives and Measures (2015 Edition)	2017 Advancing Care Information Transition Objectives and Measures (2014 Edition)

MIPS Performance Category

Advancing Care Information

Quality Payment PROGRAM

Clinicians must use certified EHR technology to report

For those using EHR Certified to the 2015 Edition:

Option 1	Option 2
Advancing Care Information Objectives and Measures	Combination of the two measure sets

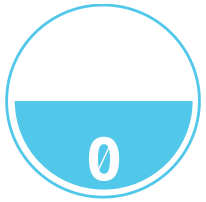
For those using 2014 Certified EHR Technology:

Option 1	Option 2
2017 Advancing Care Information Transition Objectives and Measures	Combination of the two measure sets

Advancing Care Information

Requirements for the Transition Year

Quality Payment PROGRAM



Submit Something

Test means:

- Submitting 4 or 5 base score measures
  - Depends on use of 2014 or 2015 Edition
- Reporting all required measures in the base score to earn any credit in the Advancing Care Information performance category

Submit a Partial Year

Submit a Full Year

Partial and Full means:

- Submitting more than the base score in the Transition Year
  - Ex: submitting performance and/or bonus measures in addition to the base score

For a full list of measures, please visit
QPP.CMS.GOV

Advancing Care Information

Flexibility

Quality Payment PROGRAM

1

CMS will automatically reweight the Advancing Care Information performance category to zero for Hospital-based MIPS eligible clinicians, clinicians who lack of face-to-face patient interaction, NP, PA, CRNAs and CNS

- Reporting is optional although if clinicians choose to report, they will be scored
- If these clinicians choose to report as a group, they will not be reweighted, unless the entire group is reweighted

2

A clinician can apply to have their performance category score weighted to zero and the 25% will be assigned to the Quality category for the following reasons:

1. Insufficient internet connectivity
2. Extreme and uncontrollable circumstances
3. Lack of control over the availability of CEHRT

MIPS

Scoring and Payment Adjustments

Calculating the Final Score Under MIPS

Quality Payment PROGRAM

Quality		Cost		IA		ACI		
Clinician Quality performance category score x actual Quality performance category weight	+	Clinician Cost performance category score x actual Cost performance category weight	+	Clinician Improvement Activities performance category score x actual Improvement Activities performance category weight	+	Clinician Advancing Care Information performance category score x actual Advancing Care Information performance category weight	=	100
60		0		15		25		

Transition Year 2017

Quality Payment PROGRAM

Final Score	Payment Adjustment
≥70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%
4-69 points	• Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not participate

MIPS

Strategies for Getting Started

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

Quality Payment PROGRAM

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Quality Payment PROGRAM

- **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:

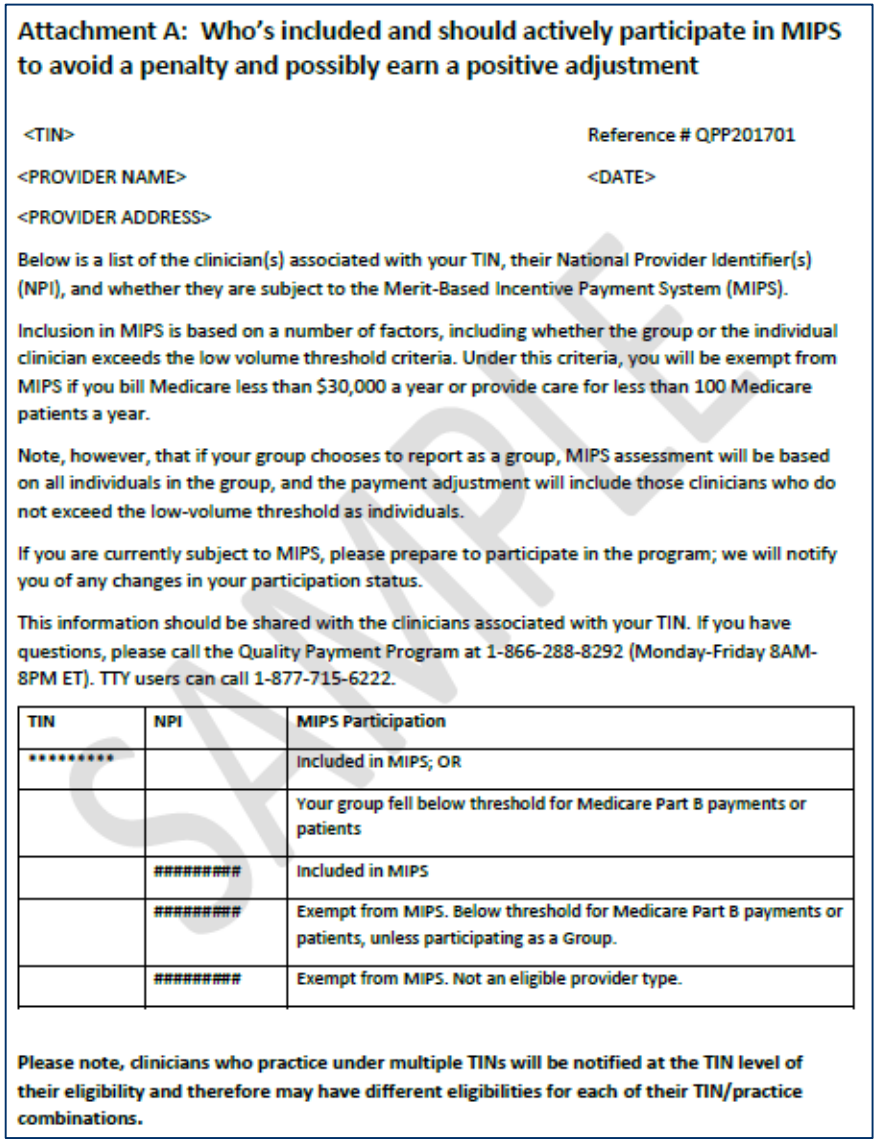
- **Visit** qpp.cms.gov for helpful resources or
- **Contact the** Quality Payment Program at QPP@cms.hhs.gov or **1-866-288-8292** (Monday-Friday 8AM-8PM ET) to find local help in your community. **TTY** users can call **1-877-715-6222**.

Getting Started: Clinician Participation Letter

Quality Payment PROGRAM

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.

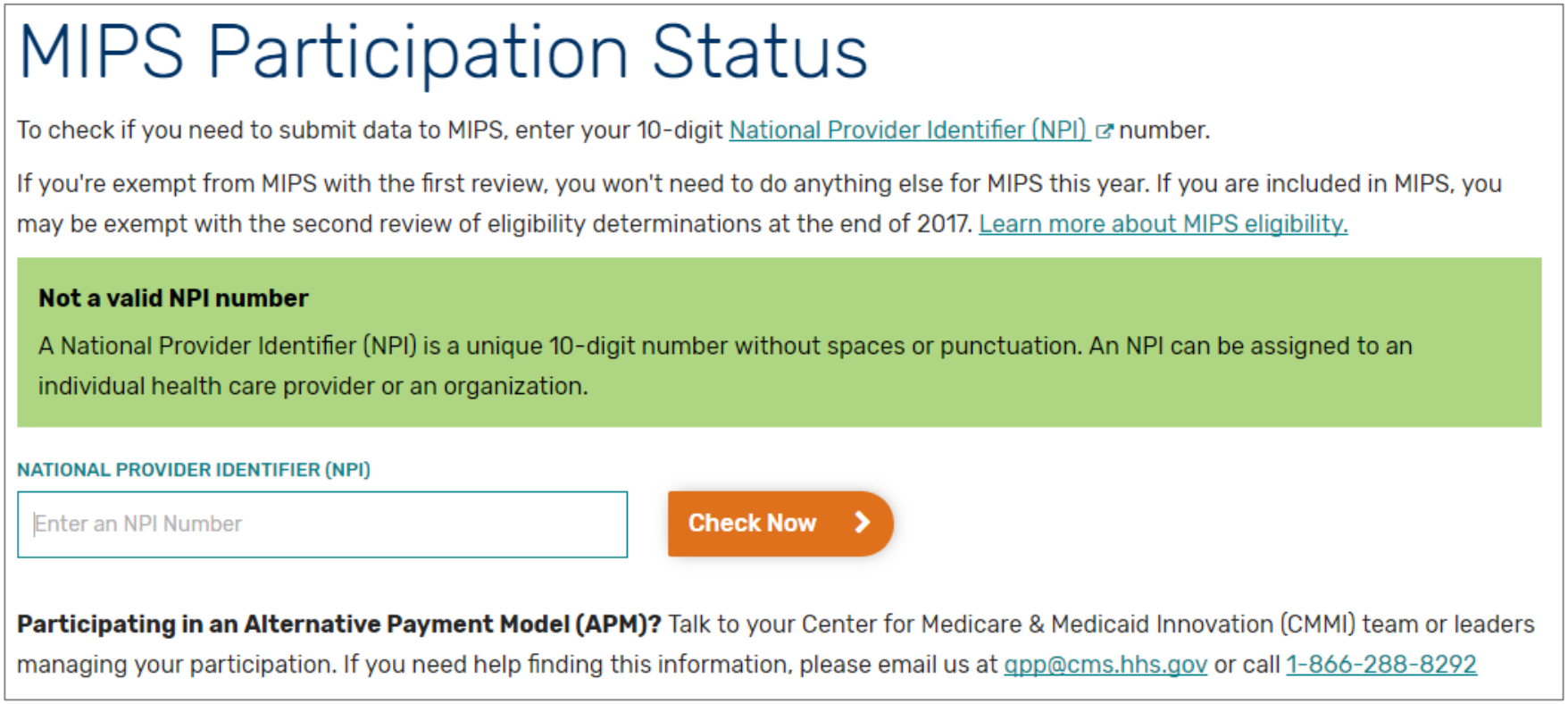
This information should be shared with the clinicians associated with your TIN. If you have questions, please call the Quality Payment Program at 1-866-288-8292 (Monday-Friday 8AM-8PM ET). TTY users can call 1-877-715-6222.

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.

You could also check your participation status by:

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



Getting Started

Quality Payment PROGRAM

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.

QUALITY PAYMENT PROGRAM

Technical Assistance

Adam Richards
Health Insurance Specialist

Technical Assistance for Clinicians

Quality Payment PROGRAM

CMS has free resources and organizations 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.

To learn more, view the Technical Assistance Resource Guide:
https://qpp.cms.gov/resources/education

Introduction to Technical Assistance

Quality Payment PROGRAM

- The available forms of technical assistance depend on how clinicians participate in the Quality Payment Program. Clinicians participating in an Advanced APM and considered Qualifying APM Participants (QPs) receive support through the APM Learning Systems.
- Clinicians participating in MIPS may receive support as a part of the Transforming Clinical Practice Initiative (TCPI) through their Practice Transformation Network (PTN).
- Alternatively, there are two other options for MIPS assistance for clinicians not enrolled in a PTN or not interested in TCPI. These include:
  - Through a Quality Innovation Network – Quality Improvement Organization (QIN-QIO) if they are in a large practice (**more than 15 clinicians**); or
  - Through Small, Underserved, and Rural Support (SURS) if they are in a small practice (**15 or fewer clinicians**), with priority given to those in rural locations, health professional shortage areas, or medically underserved areas**.**
- Finally, clinicians who are a part of an APM and are required to participate in MIPS are eligible to receive technical assistance through either the QIN-QIOs or Small, Underserved, and Rural Support, depending on practice size.

Small, Underserved, and Rural Support

Quality Payment PROGRAM

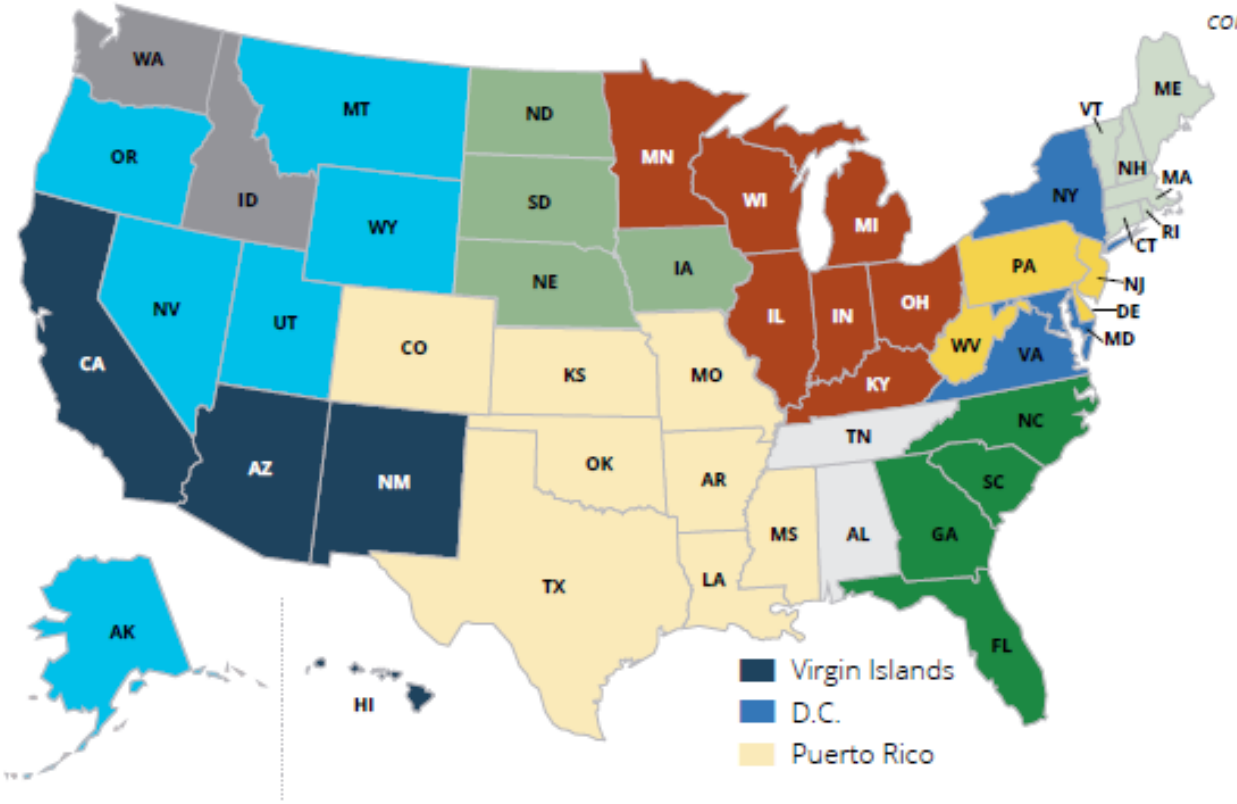
- Five-year technical assistance program authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).
- Designed for MIPS eligible clinicians in **small practices** with **15 or fewer clinicians**.
  - Includes small practices in: rural locations, health professional shortage areas (HPSAs), and medically underserved areas (MUAs).
- Goal is to provide on-the-ground support to clinicians by:
  - Assisting in the selection and reporting of appropriate Merit-based Incentive Payment System (MIPS) Quality measures and Improvement Activities;
  - Optimizing their Health Information Technology (HIT);
  - Supporting change management and strategic planning; and
  - Evaluate their options for joining an Advanced Alternative Payment Model (APM).
- Support is available immediately and is **FREE** to clinicians in small practices.

National Coverage of Technical Assistance for Small, Underserved and Rural Clinicians

Quality Payment PROGRAM

11 uniquely experienced organizations to provide national coverage to MIPS clinicians in small practices.

For general information or for help getting connected, contact QPPSURS@IMPAQINT.COM



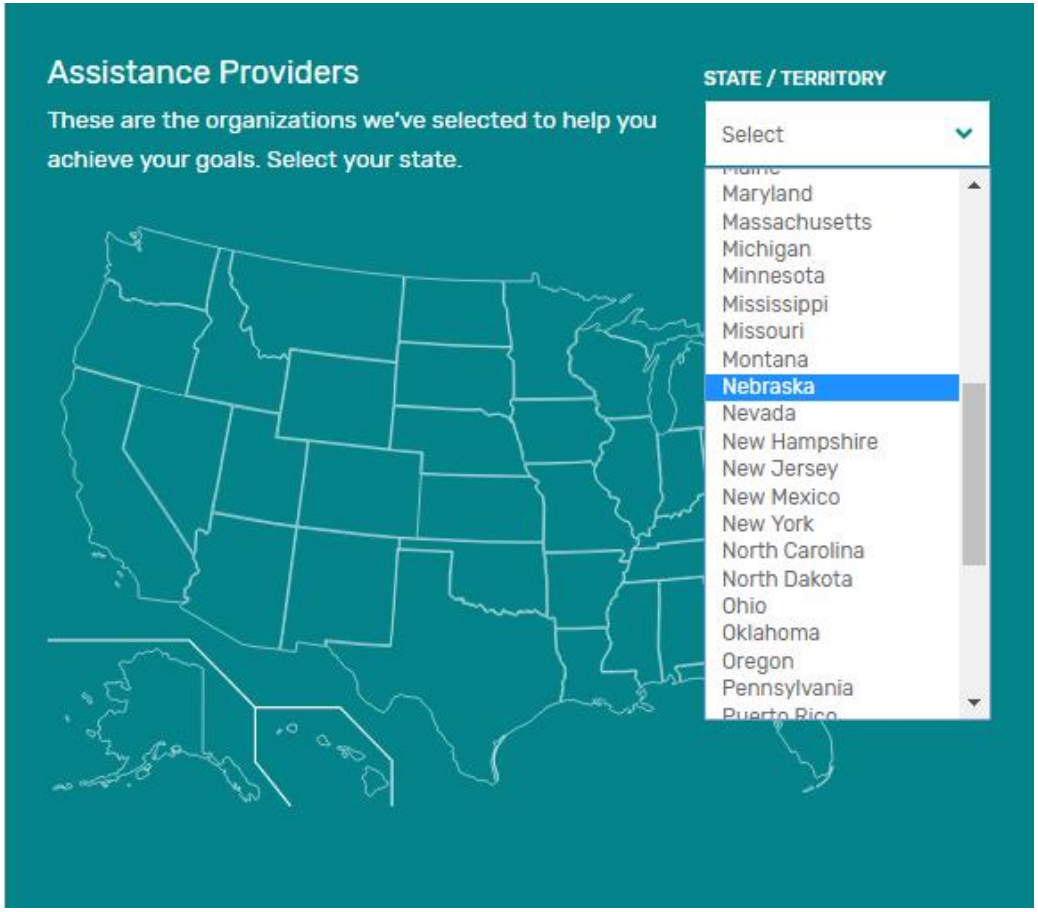
Coverage by Organization

- Healthcentric Advisors
- IPRO
- Quality Insights (WVMI)
- Alliant GMCF
- QSource
- Altarum
- TMF
- HSAG
- Telligen
- NRHI
- Qualis

Small, Underserved, and Rural Practices Webpage

Quality Payment PROGRAM

- Available on qpp.cms.gov.
- Contains contact information for the Small, Underserved, and Rural Support technical assistance organizations.
- Highlights the available options for small practices, especially those in rural and underserved locations.



PROPOSED RULE FOR YEAR 2

Merit-based Incentive Payment System

Proposed Rule: Comments Due 8/21/2017

Quality Payment PROGRAM

- Proposed changes for Year 2 of the Quality Payment Program (2018) are open for public comment:
- See the proposed rule for information on submitting these comments by the close of the 60-day comment period on **August 21, 2017**. When commenting **refer to file code CMS 5522-P**.
- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier
- For additional information, please go to: qpp.cms.gov
- For additional support, please call 1-866-288-8292 or email qpp@cms.hhs.gov

QUALITY PAYMENT PROGRAM

Comments and Q & A

Q&A Session

To ask a question, please use phone number: **1-866-452-7887**

- CMS must protect the rulemaking process and comply with the Administrative Procedure Act.
- Participants are invited to share initial comments or questions, but only comments formally submitted through the process outlined by the Federal Register will be taken into consideration by CMS.
- See the proposed rule for information on how to submit a comment.
- For additional information, please go to: qpp.cms.gov
- For additional support, please call 1-866-288-8292 or email qpp@cms.hhs.gov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