MERIT-BASED INCENTIVE PAYMENT SYSTEM FAQS

TABLE OF CONTENTS

Frequently Asked Questions

1) How do you pick your pace for MIPS Participation in 2017?

	MIPS Test Pace	MIPS Partial Year	MIPS Full Year
Quality	1 Quality measure	6 Quality measures including 1 outcome measure	6 Quality measures including 1 outcome measure
Advancing Care Information	4 or 5 required Base measures depending on CEHRT 2014 or 2015 edition	More than required 4 or 5 base measures	Required 4 or 5 base measures 9 or 7 Performance Measures
Clinical Performance Improvement Activities	1 CPIA Activity	2 Medium weighted + 1 High weighted or	2 Medium weighted + 1 High weighted
	(medium or high-weighted)	4 Medium weighted or	4 Medium weighted
		2 High weighted	2 High weighted
	MIPS Test Pace	**MIPS Partial Year**	**MIPS Full Year**
Reporting Time period	No minimum time period	90-day reporting period	Full Year
Start Date	Submit some data after January 1, 2017	Any time between January 1 – October 2	January 1-December 31 (Full year submission data)
Data Submission Dates	01/01/2018 to 03/31/2018	01/01/2018 to 03/31/2018	01/01/2018 to 03/31/2018
Deadline to submit performance data	31-Mar-18	31-Mar-18	31-Mar-18
Payment adjustment	Avoid penalties/downward adjustment	May earn a small positive adjustment or maximum positive adjustment depending on the performance data submitted	May earn a small positive adjustment or maximum positive adjustment depending on the performance data submitted
When do MIPS payment adjustments begin?	January 2019	January 2019	January 2019
Is an EHR required?	No	Yes	Yes
Practices suited for reporting option	Small Practices/Individual clinicians who never participated in Legacy CMS programs (PQRS, MU, VBM)	Small practice planning to upgrade EHR in mid-2017	Practices who have successfully participated in PQRS/MU/VBM previously
	Review and evaluate systems to understand program and data collection and submission methodology		
	Prepare for complete participation in 2018 & beyond		

2) What are the minimum requirements for reporting in the ACI category?
   a) Clinicians must possess and use Certified EHR Technology to report the ACI category measures.
   b) The minimum reporting requirements for the ACI category are the "base" measures, which are required to earn the base score.
   c) Report "Yes" to the Security Risk Analysis measure
   d) Atleast 1 patient for each measure and it can be a different patient for each measure

Advancing Care Information Objectives and Measures:

Base Score Required Measures

Measure	*Result*
Security Risk Analysis	yes
e-Prescribing	1 patient
Provide Patient Access	1 patient
Send a Summary of Care	1 patient
Request/Accept a Summary of Care	1 patient

2017 Advancing Care Information Transition Objectives and Measures:

Base Score Required Measures

Measure	*Result*
Security Risk Analysis	yes
e-Prescribing	1 patient
Provide Patient Access	1 patient
Health Information Exchange	1 patient

   e) When reporting ACI as a group, CMS will assess performance at the group TIN level, as opposed to each individual within the group. **If group can meet above requirements, it's not required that each individual clinician within the group also meet these requirements**. For example, even if only one provider within a TIN contributes data for e-prescribing measure, then the entire TIN receives credit for this measure if reporting as a group.

3) How will ACI be scored if some providers in my group are not on same EHR?
   a) If participating as a group that uses CEHRT and has performed a Security Risk Analysis, and at least one clinician in the group can report data for each measure in the base score, the group will meet the minimum reporting requirements.
   However, if no clinicians within the group are on CEHRT, group will not be able to meet the minimum requirements for the ACI category.

4) ACI Bonus Score
   a) 5% Bonus for reporting: maximum 5% bonus if you report 1 or >1 of the following 5 measures besides immunization reporting
      i) for reporting on one or more of the following Public Health and Clinical Data Registry Reporting measures:
         (1) Syndromic Surveillance Reporting (2014 and 2015)
         (2) Specialized Registry Reporting (2014)

(3) Electronic Case Reporting (2015)
(4) Public Health Registry Reporting (2015)
(5) Clinical Data Registry Reporting (2015)

b) 10% Bonus for using CEHRT to report certain CPIA activities (can be either medium or high-weighted activity)

5) Hardship exceptions apply for ACI category only under MIPS

6) Non-patient facing clinicians & Hospital-based clinicians reporting on ACI
   a) ACI category reweighted to zero
   b) However, if submit measures for ACI as a part of group, data will be scored for the group

7) Definition of non-patient facing clinicians

DEFINITION OF NON-PATIENT FACING CLINICIANS	
Individual Clinician	≤100 patient facing encounters in a designated period
Group	If > 75% of Billing NPIs under group TIN are non-patient facing in a performance period

8) MIPS reporting requirements non-patient facing clinicians

Category	Weight	REPORTING REQUIREMENTS
Quality	85%	6 quality measures including an outcome measure to earn maximum points
CPIA	15%	1 high-weighted or 2 medium weighted will earn maximum points
ACI/Cost	0%	Reweighted to "0"

9) How will CMS determine which clinicians are deemed non-patient facing?

   a) Term "non-patient facing determination period" to refer to the timeframe used to assess claims data for making eligibility regarding non-patient facing status. CMS defines the non-patient facing determination period to mean a 24-month assessment period, which includes a two-segment analysis of claims data regarding patient-facing encounters during an initial 12-month period prior to the performance period followed by another 12-month period during the performance period.
      i) The initial 12-month segment of the non-patient facing determination period would span from the last 4 months of a calendar year 2 years prior to the performance period followed by the first 8 months of the next calendar year and include a 60-day claims run out, which will allow us to **inform eligible clinicians and groups of their non-patient status during the month (December) prior to the start of the performance period.** The initial non-patient

facing determination period enables us to make eligibility determinations based on 12 months of data that is as close to the performance period as possible while informing eligible clinicians of their non-patient facing status prior to the performance period.

ii) The second 12-month segment of the non-patient facing determination period would span from the last 4 months of a calendar year 1 year prior to the performance period followed by the first 8 months of the performance period in the next calendar year and include a 60-day claims run out, which will allow CMS to inform additional eligible clinicians and groups of their non-patient status during the performance period.

b) For purposes of the 2019 MIPS payment adjustment, CMS will initially identify individual eligible clinicians and groups who are considered non-patient facing MIPS eligible clinicians based on 12 months of data starting from September 1, 2015 to August 31, 2016. To account for the identification of additional individual eligible clinicians and groups that may qualify as non-patient facing during the 2017 performance period, CMS will conduct another eligibility determination analysis based on 12 months of data starting from September 1, 2016 to August 31, 2017.

10) Definition of hospital-based clinician
    a) Under the MIPS, a hospital-based MIPS eligible clinicians is defined as a MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the Place of Service (POS) codes used in the HIPAA standard transaction as an inpatient hospital (POS 21), on campus outpatient hospital (POS 22), or emergency room (POS 23) setting, based on claims for a period prior to the performance period as specified by CMS.

11) Determination of hospital-based clinician
    a) Final rule proposes a modified final policy and will instead use claims with dates of service between September 1 of the calendar year 2 years preceding the performance period through August 31 of the calendar year preceding the performance period. For example, for **the 2017 performance period (2019 MIPS payment year)** we will use the data available at the end of October 2016 for Medicare claims with **dates of service between September 1, 2015, through August 31, 2016**, to determine whether a MIPS eligible clinician is considered hospital-based by our definition.
    b) If it is not operationally feasible to use claims from this exact time period, CMS will use a 12-month period as close as practicable to September 1 of the calendar year 2 years preceding the performance period and August 31 of the calendar year preceding the performance period.

12) MIPS reporting requirements for rural and small practices
    a) Reducing the time and cost to participate
    b) Providing opportunities to participate in Test pace, MIPS Partial year & MIPS Full Year
    c) Increasing the opportunities to participate in Advanced APMs

d) Including a practice-based option for participation in Advanced APMs as an alternative to total cost-based
e) Conducting technical support and outreach to small practices through the forthcoming Quality Payment Program, Small, Rural and Underserved Support (QPP-SURS) as well as through the Transforming Clinical Practice Initiative
f) Established low-volume threshold
    i) Less than or equal to $30,000 in Medicare Part B allowed charges **OR**
    ii) Less than or equal to 100 Medicare patients
g) Reduced requirements for Improvement Activities performance category
    i) One high-weighted activity **OR**
    ii) Two medium-weighted activities
h) Increased ability for clinicians practicing at Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) to qualify as a Qualifying APM Participant (QP)

13) How will CMS determine newly enrolled clinicians exempt from MIPS for their first performance year
    a) **Definition of a new Medicare-enrolled eligible clinician** as a professional who first becomes a Medicare-enrolled eligible clinician within the PECOS during the performance period for a year and who has not previously submitted claims as a Medicare-enrolled eligible clinician either as an individual, an entity, or a part of a physician group or under a different billing number or tax identifier
    b) Eligible clinician will not be treated as a MIPS eligible clinician until the subsequent year and performance period for that year
    c) New Medicare-enrolled eligible clinicians are excluded from MIPS during the performance period in which they are identified as being a new Medicare-enrolled eligible clinician.
        i) For example, if an eligible clinician becomes a new Medicare-enrolled eligible clinician in April of a particular year, such eligible clinician would be excluded from MIPS until the subsequent year and performance period for that year, in which such eligible clinician would be required to participate in MIPS starting in January of the next year.
    d) Eligible clinicians would be treated as a MIPS eligible clinician in their subsequent year of being a Medicare-enrolled eligible clinician, required to participate in MPS, and subject to the MIPS payment adjustment for the performance period of that subsequent year.
    e) Beneficial for eligible clinicians to know during the performance period of a calendar year whether or not they are identified as a new Medicare-enrolled eligible clinician.
        i) Term **"new Medicare-enrolled eligible clinician determination period"** and define it to mean the 12 months of a calendar year applicable to the performance period.
        ii) During the new Medicare-enrolled eligible clinician determination period, CMS will conduct eligibility determinations on a quarterly basis to the extent that is technically feasible to

identify new Medicare-enrolled eligible clinicians that would be excluded from the requirement to participate in MIPS for the applicable performance period

iii) Given that the performance period is a minimum of one continuous 90-day period within CY 2017, CMS believes it would be beneficial for such eligible clinicians to be identified as being excluded from MIPS requirements on a quarterly basis in order for individual eligible clinicians or groups to plan and prepare accordingly

14) **Clarification regarding whether or not clinicians excluded from MIPS would also be excluded from group-level reporting**

a) There are three types of MIPS exclusions:
   i) New Medicare-enrolled eligible clinicians,
   ii) QPs and Partial QPs who do not report on applicable MIPS measures and activities, and
   iii) Eligible clinicians who do not exceed the low-volume threshold

b) Exclusion criterion & reporting for 2 types of exclusions
   i) New Medicare-enrolled eligible clinicians, and QPs and Partial QPs who do not report on applicable MIPS measures and activities are **determined at the individual (NPI) level**
   ii) Low-volume threshold exclusion is determined at **the individual (TIN/NPI) level for individual reporting** and at the **group (TIN) level for group reporting.**

c) A group electing to submit data at the group level would have its performance assessed and **scored** across the TIN, which could include items and services furnished by individual NPIs within the TIN who are not required to participate in MIPS.
   i) For example, excluded eligible clinicians (new Medicare-enrolled, QPs, or Partial QPs who do not report on applicable MIPS measures and activities, and do not exceed the low-volume threshold) are part of the group, and therefore, would be considered in the group's score.

d) However, the **MIPS payment adjustment** would apply differently at the group level in relation to each exclusion circumstance.
   i) For example, groups reporting at the group level that include new Medicare-enrolled eligible clinicians, or QPs or Partial QPs would have the MIPS payment adjustment only apply to the Medicare Part B allowed charges pertaining to the group's MIPS eligible clinicians and the MIPS payment adjustment would not apply to such clinicians excluded from MIPS based on these two types of exclusions.
   ii) Thus, eligible clinicians (TIN/NPI) who do not exceed the low-volume threshold at the individual reporting level and would otherwise be excluded from MIPS participation at the individual level, would be required to participate in MIPS at the group level if such eligible clinicians are part of a group reporting at the group level that exceeds the low-volume threshold.
   iii) Any individual (NPI) excluded from MIPS because they are identified as new Medicare-enrolled, QP, or Partial QP would not receive a MIPS payment adjustment, regardless of their MIPS participation.

15) What is the process of validation of submission of 6 quality measures?
    a) **Eligible clinicians who fail to report a measure that is required to satisfy the quality performance category submission criteria will receive zero points for that measure.**
    b) The MIPS validation process will vary by submission mechanism
    c) Further, CMS finalized implementation of a validation process for claims and registry submissions to validate whether MIPS eligible clinicians have six applicable and available measures, whether an outcome measure is available or another other high priority measure if an outcome measure is not available.
    d) For claims and registry submissions, CMS plans to use the cluster algorithms from the current MAV process under PQRS to identify which measures an MIPS eligible clinician reports.
    e) **For QCDRs, CMS does not intend to establish a validation process.** MIPS eligible clinicians that enroll in QCDRs have sufficient meaningful measures to report.
    f) For the EHR submissions, MIPS eligible clinicians may not have six measures relevant within their EHR. If there are not sufficient EHR measures to meet the full specialty set requirements or meet the requirement to submit 6 measures, the MIPS eligible clinician should select a different submission mechanism to meet the quality performance category requirements of submitting measures in a specialty set or six applicable measures. MIPS eligible clinicians should work with their EHR vendors to incorporate applicable measures as feasible.
    g) For the CMS Web Interface, MIPS eligible clinicians are attributed beneficiaries on a defined population that is appropriate for the measures, so there is no need for additional validation.

16) Impact of negative findings from audits of third party vendors on MIPS eligible clinicians
    a) Data inaccuracies on the part of the third-party vendor will be considered when the third party intermediary requests to continue participation in the Quality Payment Program in subsequent years (self-nomination).
    b) Data inaccuracies discovered during an audit of a third-party intermediary and occurring due to inaccurate data submitted by the MIPS eligible clinician or group, could result in the MIPS eligible clinician or group's data being reviewed as well.
    c) As a general matter, the contractual agreement or other arrangement between a MIPS eligible clinician or groups and a third-party intermediary is not within CMS authority to control and they are not a party to such agreements or arrangements. However, CMS has noted that MIPS eligible clinicians and groups may be able to seek recourse against their third-party intermediary if significant issues or problems arise.
    d) Notwithstanding, MIPS eligible clinicians and groups are ultimately responsible for the data submitted by their third-party intermediary on their behalf and CMS expects MIPS eligible clinicians and groups to hold their third party intermediary accountable for accurate data submissions. Moreover, CMS suggest that MIPS eligible clinicians and groups work with their third-party intermediary to ensure data is submitted timely and accurately.

17) Working requirements with a third-party vendor

Intermediary	Approval Needed	Cost to Clinician
EHR Vendor	EHR Vendors Must be certified by ONC	×
QCDR	QCDRs must be approved by CMS	×
Qualified Registry	Qualified registries must be approved by CMS	×
CMS Approved CAHPS Vendor	CAHPS Vendors must be approved by CMS	×

18) Question on whether a MIPS eligible clinician can earn bonus points if the MIPS eligible clinician does not report all 6 measures due to lack of available measures.
    a) The MIPS eligible clinician can receive bonus points on all high priority measures submitted, after the first required high priority measure submitted, assuming these measures meet the minimum case size and data completeness requirements even if the MIPS eligible clinician did not report all 6 required measures due to lack of available measures.

19) **An Alternative Payment Model (APM)** is a payment arrangement, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care.
    a) APMs can focus on
        i) a specific clinical condition
        ii) a care episode
        iii) a population
    b) Examples
        i) CMS Innovation Center models (except the Health Care Innovation Awards)
        ii) Medicare Shared Savings Program tracks, and
        iii) certain other federal demonstrations

20) **Advanced APMs are a subset of APMs** and enable clinicians and practices to earn more rewards for taking on some risk related to patients' outcomes
    a) Clinicians who participate to a sufficient degree in Advanced APMs are excluded from MIPS and earn a 5 percent lump sum incentive payment based on their Part B professional services for a given year.
    b) Quality Payment Program does not change the design of any APM. Instead, it creates **extra incentives** for a sufficient degree of participation in Advanced APMs.
    c) Total Advanced APMs = **Advanced APM specific rewards + 5% lump sum incentive**

21) Comparison of Potential Financial Rewards

	MIPS Adjustments	MIPS Adjustments under "APM-Scoring Standards"	APM-specific rewards	5% lump sum bonus
MIPS	×			
MIPS-APM*		×	×	
In Advanced APM (if you are a Qualifying APM Participant (QP)			×	×

MIPS-APM* Not scored on Cost; Receive 40 points (full credit) for IA, Quality measures are reported through APM entity & do not report separately on Quality measures

22) Advanced APMs must meet the following requirements:
   a) Require participants to use certified electronic health record technology (CEHRT)
   b) Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS)
   c) Either: (1) be a Medical Home Model expanded under CMS Innovation Center authority; or (2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses

23) Advanced APMs in 2017
   a) Comprehensive ESRD Care (CEC) Model (LDO arrangement)
   b) Comprehensive ESRD Care (CEC) Model (non-LDO two-sided risk arrangement)
   c) Comprehensive Primary Care Plus (CPC+) Model
   d) Medicare-Medicaid Accountable Care Organization Model (MMACO) (for participants in Shared Savings Program Track 2)
   e) Medicare-Medicaid Accountable Care Organization Model (MMACO) (for participants in Shared Savings Program Track 3)
   f) Medicare Shared Savings Program Accountable Care Organizations — Track 2
   g) Medicare Shared Savings Program Accountable Care Organizations — Track 3
   h) Next Generation ACO Model
   i) Oncology Care Model (OCM) (two-sided Risk Arrangement)
   j) Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

24) Advanced APMs Beginning Performance Year 2018
   a) Coronary Artery Bypass Graft (CABG) Model (Track 1 – CEHRT)
   b) Surgical Hip/Femur Fracture Treatment (SHFFT) Model (Track 1 – CEHRT)
   c) Medicare Accountable Care Organization (ACO) Track 1+ Model

25) How Does an Eligible Clinician Qualify for the 5 Percent Incentive Payment and MIPS Exemption?
    a) To become a Qualifying APM Participant (QP), an eligible clinician—assessed as part of an APM Entity or, in certain cases, individually—must receive
        i) a certain percentage of Part B payments for professional services or
        ii) see a certain percentage of patients furnished Part B professional services through Advanced APMs or,
    b) The QP determination process assesses the relative degree of participation in Advanced APMs and Other Payer Advanced APMs, not the eligible clinician's performance success as assessed under the payment arrangements.

26) **Partial QPs:** Clinicians who participate in Advanced APMs, but do not meet the QP threshold, may become "Partial" Qualifying APM Participants (Partial QPs)
    a) Partial QPs do not receive the 5 percent incentive payment, but they may choose whether to participate in MIPS

27) MIPS APM are subset of APMs
    a) Certain APMs include MIPS eligible clinicians as participants and hold their participants accountable for the cost and quality of care provided to Medicare beneficiaries. This type of APM is called a "MIPS APM," and participants in MIPS APMs have MIPS special reporting requirements and receive special MIPS scoring under the "APM scoring standard."

28) MIPS APMs for 2017
    a) Comprehensive ESRD Care (CEC) Model (LDO arrangement)
    b) Comprehensive ESRD Care (CEC) Model (non-LDO two-sided risk arrangement)
    c) Comprehensive ESRD Care (CEC) Model (non-LDO arrangement one-sided risk arrangement)
    d) Comprehensive Primary Care Plus (CPC+) Model
    e) Medicare-Medicaid Accountable Care Organization Model (MMACO) (for participants in Shared Savings Program Track 1)
    f) Medicare-Medicaid Accountable Care Organization Model (MMACO) (for participants in Shared Savings Program Track 2)
    g) Medicare-Medicaid Accountable Care Organization Model (MMACO) (for participants in Shared Savings Program Track 3)
    h) Medicare Shared Savings Program Accountable Care Organizations — Track 1
    i) Medicare Shared Savings Program Accountable Care Organizations — Track 2
    j) Medicare Shared Savings Program Accountable Care Organizations — Track 3
    k) Next Generation ACO Model
    l) Oncology Care Model (OCM) (one-sided Risk Arrangement)
    m) Oncology Care Model (OCM) (two-sided Risk Arrangement)
    n) Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

29) Requirements to be considered a MIPS APM
   a) APM Entities participate in the APM under an agreement with CMS
   b) APM Entities include one or more MIPS eligible clinicians on a Participation List
   c) APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on cost/utilization and quality

30) When Will Clinicians Learn their QP Status?
   a) To be considered part of the APM Entity for the APM scoring standard, an eligible clinician must be on an APM Participation List on at least one of the following three snapshot dates **(March 31, June 30, or August 31)** of the performance period
   b) Otherwise an eligible clinician must report to MIPS under the standard MIPS methods.

31) Shared Savings Program Comparison

Shared Savings Track 1	**Shared Savings Track 2**	**Shared Savings Track 3**
MIPS APM	Advanced APM	Advanced APM
MIPS eligible clinicians in ACOs are subject to **MIPS under the APM scoring standard**.	Participating eligible clinicians who are determined to be Qualifying APM Participants are exempt from MIPS.	Participating eligible clinicians who are determined to be Qualifying APM Participants are exempt from MIPS.
All MIPS eligible clinicians in the APM Entity are considered a group and will receive the same score.		

32) How do Eligible Clinicians become Qualifying APM Participants?
   a) 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%

33) What are Partial QP Thresholds in Advanced APMs?

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%

34) CPIA: Entire group TIN can get credit for CPIA category if a single clinician in a TIN works in PCMH

35) Registration requirements
   a) Registration is required **ONLY** for Eligible clinicians participating as a group via Web Interface & CAHPS for MIPS survey (ACOs do not have to register to report for Web Interface)
   b) Registration open from April 1, 2017 to June 30, 2017

36) CAHPS for MIPS survey is optional for any group size under MIPS

37) Reporting for 90-day performance period for MIPS partial year
   a) All clinicians within in a group with same TIN must report for the same 90-day period for each individual category
   b) All clinicians in the group must be reporting same quality measures

References:

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