Quality Payment
PROGRAM

AN INTRODUCTION TO:

Group Participation in the Merit-based Incentive Payment System (MIPS) in 2018

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How to Use This Guide

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Resource Icon

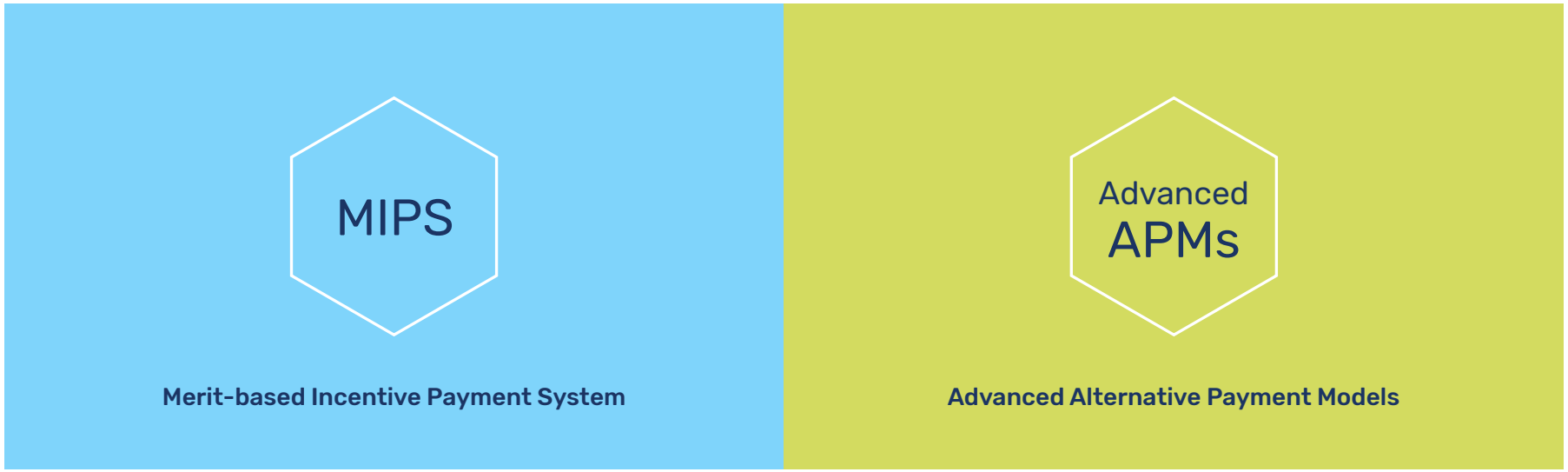
This guide includes an icon to alert the reader that there are additional resources on the specific topic being discussed.

Please note: *This guide was prepared for informational purposes only and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It is not intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.*

OVERVIEW

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. MACRA requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, which provides two participation tracks for clinicians:



This guide focuses on group participation in MIPS. Visit qpp.cms.gov for information on other topics related to the Quality Payment Program.

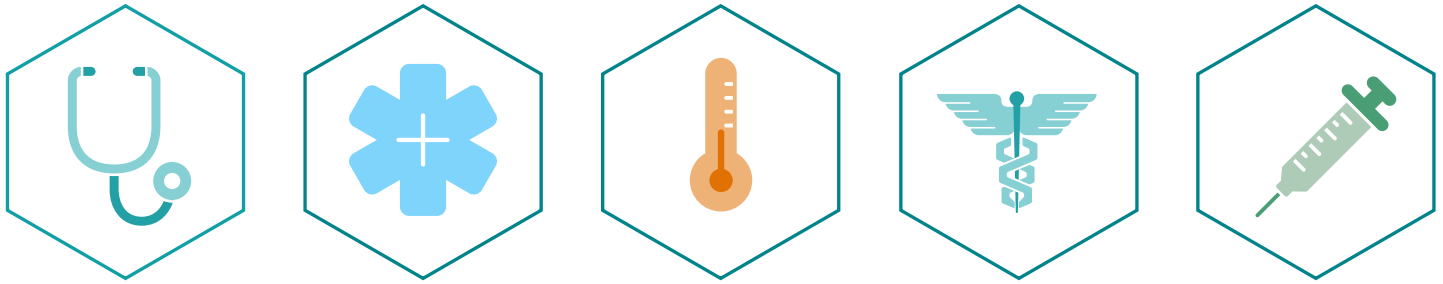
What is MIPS?

MIPS eligible clinicians receive a payment adjustment based on performance in four categories:

Highlights of Category in Year 2 (2018)			
Quality	**Cost**	**Improvement Activities**	**Promoting Interoperability** (formerly called Advancing Care Information)
			
• Assesses the quality of care to ensure patients get the right care at the right time • 50% of MIPS score	• Helps create efficiencies in Medicare spending • No data submission requirement (other than claims submission) • 10% of MIPS score	• Supports expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, participation in an APM, achieving health equity, emergency preparedness and response, and integrated behavioral and mental health • 15% of MIPS score	• Supports the secure exchange of health information and the use of certified EHR technology • 25% of MIPS score

Who participates in MIPS?

CMS describes clinicians who participate in MIPS as MIPS eligible clinicians. For the first two years of MIPS (2017 and 2018 MIPS performance periods), MIPS eligible clinicians include:



Physicians*

Physician Assistants

Nurse Practitioners

Clinical Nurse Specialists

Certified Registered Nurse Anesthetists

***Physicians** (doctors of medicine, doctors of osteopathy [including osteopathic practitioners], doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors)

Any clinician group that includes one of the clinicians listed above

With respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.

Who is not eligible to participate in MIPS?

Clinician types that are not included in the definition of a MIPS eligible clinician, as identified above, are not eligible to participate in MIPS, and receive a MIPS payment adjustment. Also, MIPS eligible clinicians may be eligible for an exclusion. If a MIPS eligible clinician qualifies for one of four exclusions, then the clinician would not be eligible to participate in MIPS and receive a MIPS payment adjustment, except in the one noted below.

1	Clinicians who enroll in Medicare for the first time during a MIPS performance period are not eligible to submit data on measures and activities for MIPS until the following performance period.
2	Qualifying APM Participants (QPs) are not considered MIPS eligible clinicians and are not eligible to participate in MIPS.
3	Partial QPs may choose to participate in MIPS. If a partial QP does not submit data on measures and activities that are required to be submitted under MIPS for a given performance period in a year, they are not considered a MIPS eligible clinician.
4	A MIPS eligible clinician or group that does not exceed the low-volume threshold (has less than or equal to $90,000 in allowed Part B charges for covered professional services under the Physician Fee Schedule (PFS) or furnishes covered professional services to 200 or fewer Part B-enrolled beneficiaries under a given TIN is not eligible to participate in MIPS for the 2018 performance period under that TIN.

Note: Clinicians who are not eligible to participate in MIPS individually because they do not exceed the low-volume threshold as individuals **are included in MIPS** if their group exceeds the low-volume threshold at the group level and elects to participate as a group.

For the 2017 performance period, low-volume threshold calculations were based on all Medicare Part B allowed charges and Part B items and services furnished to patients. However, the Bipartisan Budget Act of 2018 included a provision that affects how MIPS eligibility is determined with respect to the low-volume threshold. Beginning with performance periods in 2018, the calculations will now be based on the amount of Medicare Physician Fee Schedule allowed charges for covered professional services and Physician Fee Schedule furnished to Part B-enrolled beneficiaries.

Can non-patient facing, hospital-based, and Ambulatory Surgical Center (ASC)-based clinicians participate?

Non-patient facing, hospital-based, and ASC-based clinicians participate in MIPS as long as they exceed the low-volume threshold, are not newly enrolled, and are not a QP, or a Partial QP who elects not to report data to MIPS.

A group is considered non-patient facing if more than 75% of eligible clinicians (NPIs) billing under the group's TIN during a performance period are determined to be non-patient facing.

A group is considered hospital-based if 100% of MIPS eligible clinicians billing under the group's TIN during a performance period are determined to be hospital-based.

A group is considered ASC-based if 100% of MIPS eligible clinicians billing under the group's TIN during a performance period are determined to be ASC-based.

There are special scoring considerations for MIPS eligible clinicians and groups that are identified as non-patient facing, hospital-based, and/or ASC-based.

How is a group defined under MIPS?

A group is defined as a single Taxpayer Identification Number (TIN) with two or more eligible clinicians (including at least one MIPS eligible clinician) as identified by their National Provider Identifiers (NPI) who have reassigned their Medicare billing rights to the TIN. Groups have the option to submit data at the individual (NPI) or group (TIN/NPI) level. For groups that elect to submit data at the group level, they are required to:

- Meet the definition of a group at all times during the performance period for the MIPS payment year; and
- Aggregate their performance data across the TIN in order to have their performance assessed as a group.

A group that elects to have its performance assessed as a group will be assessed as a group across all four MIPS performance categories and MIPS eligible clinicians in the group will receive a payment adjustment based on the group's performance.

Note: For the 2017 performance period, we heard stakeholder concerns regarding clinicians who joined a practice (TIN) between September 1 and December 31, 2017. As we work to address these concerns for 2017, we are also investigating our options for the 2018 performance period. We will update this guide as more information becomes available.

How is a group different from a virtual group under MIPS?

To encourage broader MIPS participation for solo practitioners and groups with 10 or fewer eligible clinicians, the option to form a virtual group is available starting with the CY 2018 performance period.

An important distinction between the definition of a group and virtual group is the number of Taxpayer Identification Numbers (TINs) involved in the group or virtual group.

- A group is defined as a **single TIN** with two or more eligible clinicians (including at least one MIPS eligible clinician) as identified by their National Provider Identifiers (NPI) who have reassigned their Medicare billing rights to the TIN.
- A virtual group is defined as a **combination of two or more TINs** assigned to one or more solo practitioners (who are also MIPS eligible clinicians) or to one or more groups consisting of 10 or fewer eligible clinicians (including at least 1 MIPS eligible clinician), or both, that elect to form a virtual group for a performance period for a year.

How are groups assessed and scored if groups include clinicians who are not eligible to participate in MIPS?

Since clinicians have the option to submit data at the individual (TIN/NPI) or group level (TIN), the following outlines how a MIPS group's (TIN) performance is assessed and scored at the group (TIN) level and how the MIPS payment adjustment is applied when a group includes clinicians who are excluded from MIPS at the individual level.

There are four types of MIPS exclusions: 1) new Medicare-enrolled clinicians, 2) QPs, and 3) Partial QPs who do not report on applicable MIPS measures and activities, and 4) clinicians who do not exceed the low-volume threshold, which determine when a clinician is not considered a MIPS eligible clinician and thus, not required to participate in MIPS.

The three types of exclusions pertaining to new Medicare-enrolled clinicians, and QPs and Partial QPs who do not submit data on applicable MIPS measures and activities, are determined at the individual (NPI) level. The low-volume threshold exclusion is determined at the individual (TIN/NPI) level for individual participation and at the group (TIN) level for group participation.

Assessment, Scoring, and Payment Adjustment: Groups with Clinicians Not Eligible to Participate in MIPS Due to an Exclusion

A group electing to submit data at the group level will 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. For example, excluded clinicians are part of the group, and therefore, would be considered in the group's score.

However, the MIPS payment adjustment would apply differently in relation to each exclusion circumstance. For example, for groups participating at the group level that include new Medicare-enrolled clinicians, QPs, or Partial QPs that choose not to participate, the MIPS payment adjustment would only apply to payments for covered professional services furnished by MIPS eligible clinicians. It would not apply to such clinicians excluded from MIPS based on these two types of exclusions. Any individual (NPI) excluded from MIPS because they are identified as new Medicare-enrolled, QP, or Partial QP (and choose not to participate) would not receive a MIPS payment adjustment, regardless of their MIPS participation.

The low-volume threshold is different from the other two exclusions because it is not determined solely based on the individual NPI status. It is based on both the TIN/NPI (to determine an exclusion at the individual level) and TIN (to determine an exclusion at the group level) status. For group-level participation, the group, as a whole, is assessed to determine if the group (TIN) exceeds the low-volume threshold. Thus, clinicians (TIN/NPI) who do not exceed the low-volume threshold at the individual participation level and would otherwise be excluded from MIPS participation at the individual level, will be required to participate in MIPS at the group level if such clinicians are part of a group participating at the group level and that group exceeds the low-volume threshold. Such clinicians would receive a MIPS payment adjustment based on the group level performance.

Let's look at an example

A group has four physicians (MIPS eligible clinician type) on staff, all of whom have reassigned their billing rights to the TIN.

- Clinician A enrolled in Medicare during the performance period
- Clinician B enrolled in Medicare prior to the performance period, but didn't exceed the low-volume threshold as an individual at this practice
- Clinicians C and D each enrolled in Medicare prior to the performance period, and exceed the low-volume threshold as individuals at this practice

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The group has decided to participate at the group level and submits aggregated data collected from all four physicians. The group earns a final score that corresponds to a 3+% payment adjustment based on their performance. The payment adjustment will be applied to the payments for covered professional services furnished by Clinicians B, C and D in the payment year; Clinician A is not eligible to participate in MIPS because he is newly enrolled in Medicare and will not receive the MIPS payment adjustment. The payment adjustment will be applied to Clinician B because the low-volume threshold is applied at the group level for group reporting.

Assessment, Scoring, and Payment Adjustment: Groups with Clinicians that Do Not Meet the Definition of a MIPS Eligible Clinician

Individual clinicians who do not meet the definition of a MIPS eligible clinician during the first two years of MIPS—such as physical and occupational therapists, clinical social workers, and others—are not MIPS eligible and are not required to participate in MIPS. However, they may **voluntarily** report measures and activities for MIPS. Clinicians who are not MIPS eligible who voluntarily submit data for MIPS at the individual level will not receive a MIPS payment adjustment.

Groups participating at the group level must include all such clinicians in its aggregated data that will be submitted for measures and activities under MIPS. Groups participating at the group level will have their performance assessed and scored across the TIN; however, those clinicians that do not meet the definition of a MIPS eligible clinician will not receive a MIPS payment adjustment regardless of their MIPS voluntary participation.

Let's look at an example

A group has a physical therapist (Clinician A) and three physicians (Clinicians B, C and D) on staff, all of whom have reassigned their billing rights to the TIN.

- Clinician A is a physical therapist which is not a MIPS eligible clinician type
- Clinician B is a MIPS eligible clinician type, but didn't exceed the low-volume threshold as an individual at this practice
- Clinicians C and D are MIPS eligible clinician types, and exceed the low-volume threshold as individuals at this practice

The group has decided to participate at the group level and chooses to submit aggregated data collected from all four clinicians. The group earns a final score that corresponds to a 2+% payment adjustment based on their performance. The payment adjustment will be applied to the payments for covered professional services furnished by Clinicians B, C and D in the payment year. The payment adjustment will be applied to Clinician B because the low-volume threshold is applied at the group level for group reporting. The payment adjustment will not be applied to Clinician A because she is not a MIPS eligible clinician type.

GROUP PARTICIPATION AT A GLANCE

What does group participation look like under MIPS?

The following table provides a high-level overview of the different aspects of group participation which are explored in greater detail throughout this guide.

MIPS	
Participation and Eligibility	
	To participate in MIPS as a group, the group must exceed the established low-volume threshold and include at least one MIPS eligible clinician.
Registration	
	Registration is only required to submit data as a group if the group elects to submit data via the CMS Web Interface and/or administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey. Otherwise, to participate in MIPS as a group, groups are not required to register.

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MIPS

Submission Mechanisms

For each of the Quality, Improvement Activities, and Promoting Interoperability performance categories, groups can choose from a list of available submission mechanisms.

Depending on the MIPS performance category, groups or virtual groups can choose from the following submission mechanisms:

- Qualified Clinical Data Registry (QCDR)
- Qualified Registry
- Electronic Health Record (EHR)
- CMS Web Interface (only available for registered groups with 25 or more clinicians)
- Attestation (for Improvement Activities and Promoting Interoperability performance categories)

Groups and virtual groups of any size have the option to administer the CAHPS for MIPS survey as one of their quality measures; the remaining quality measures must be submitted through one of the approved submission mechanisms.

Scoring

A group electing to submit data at the group level would have its performance assessed and scored across the TIN, which could include covered professional services furnished by individual NPIs within the TIN who are not required to participate in MIPS.

A MIPS eligible clinician participating via a group will get the group's score. However, if the same MIPS eligible clinician also submits individual level data, CMS will use the higher of the two final scores for that clinician.

continued

MIPS

Payment Adjustments

Each MIPS eligible clinician included in the group will receive a payment adjustment based on the group's performance.

MIPS MILESTONES

What are the important participation milestones for MIPS?

Participation and data submission deadlines for the 2018 performance period are included in the chart below.

Milestones						
January 1, 2018	**April 1, 2018**	**June 30, 2018**	**October 3, 2018**	**December 31, 2018**	**January 2 , 2019 – March 31, 2019**	**July 2019**
2018 MIPS performance period begins.	Registration period begins for the CMS Web Interface and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey. (Please note that this is only registration required for groups.)	Registration deadline for the CMS Web Interface and CAHPS for MIPS survey.	The final day to start data collection for a 90-day performance period (applicable to the Improvement Activities and Promoting Interoperability performance categories.)	2018 MIPS performance period ends. Deadline for submitting a Promoting Interoperability hardship exception request.	MIPS data submission period for the 2018 performance period. (Note the CMS Web Interface has an 8-week submission period within this timeframe.)	Performance feedback will be available.

REGISTRATION

Does the group need to register to participate in MIPS as a group?

Not all groups participating in MIPS need to register. Groups need to register on qpp.cms.gov if they elect to submit data via the CMS Web Interface and/or administer the CAHPS for MIPS survey. The registration period is from April 1 to June 30, 2018.

If your group registered for the CMS Web Interface in 2017, CMS will automatically register your group to use the CMS Web Interface in 2018 for MIPS.

CMS does not require registration for groups submitting data via Qualified Registry, QCDR, or EHR.

Groups that participate in a Shared Savings Program ACO are not required to register; these Advanced Alternative Payment Models (Advanced APMs) are required to submit quality measures through the CMS Web Interface at the APM entity level, on behalf of participating MIPS eligible clinicians in the ACO's participant TINs for purposes of MIPS. However, groups (participant TINs) that are planning to terminate their agreement with the Medicare Shared Savings Program can register so they can submit their quality data at the group level using the CMS Web Interface.

Certain Advanced APMs such as Next Generation ACOs allow "split TINs", where some of the clinicians under the group's TIN participate in the model while others do not. If a "split TIN" group is eligible for MIPS, the group can register to submit data through the CMS Web Interface (if they meet group size requirements) and/or to administer CAHPS for MIPS survey. This would be separate from any APM entity data submission required by the model which would only apply to the clinicians participating in the model.

Can the group cancel their registration?

Groups that register to use the CMS Web Interface and/or administer the CAHPS for MIPS survey prior to the registration deadline (June 30) can cancel their registration only during the timeframe before the close of registration.

Groups that registered for the CMS Web Interface in 2017 and were automatically registered for 2018 can cancel their registration during this timeframe if they plan to submit data through another submission mechanism for MIPS. However, groups that miss the deadline to cancel their automatic registration can still submit their quality measures through a different submission mechanism.

DATA SUBMISSION MECHANISMS

How do I submit data for each performance category?

As discussed in the Overview section, MIPS has four performance categories, including Quality, Improvement Activities, Promoting Interoperability and Cost. The Cost performance category does not have a separate data submission requirement, as these measures are calculated automatically using administrative claims data.

Groups can submit data using different submission mechanisms for each performance category that require data submission by the group. Groups may also submit data through multiple submission mechanisms for a single performance category, but their category score will only be based on the data submitted through a single mechanism.

For example, a group could submit data for six quality measures by directly submitting their own EHR data, and six quality measures through a qualified registry. The group would receive one score for the six measures submitted by EHR and another score for the six measures submitted on their behalf by a qualified registry. The higher of the two scores would count as their Quality performance category score and would contribute to their final score.

Groups should consider which submission mechanism best fits their group when determining the type of submission mechanism to use.

Performance Category	Data Submission Mechanisms
Quality	• **Administrative Claims** – The Quality performance category has one measure that is an administrative claims measure, the All-Cause Hospital Readmission measure. Groups of 16 or more clinicians are subject to the All-Cause Hospital Readmission measure if 200 patients are attributed. If 200 patients are not attributed, the All-Cause Hospital Readmission measure will not be calculated, and clinicians will only be scored on the reported six measures, for a total possible score of 60 points (with the exception of CMS Web Interface reporters). No data submission action is required for administrative claims.

Performance Category	Data Submission Mechanisms
Quality	• **Qualified Registry** – Qualified Registry is a CMS approved entity that collects clinical data from a clinician or group and submits it to CMS on their behalf. • **Qualified Clinical Data Registry Reporting (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. • **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. • **CMS Web Interface** – A secure internet-based data submission option for registered groups of 25 or more clinicians submitting quality data to CMS. The CMS Web Interface is partially pre-populated with claims data from the group's Medicare Part A and B beneficiaries who have been assigned to the group. The group then completes quality data for the pre-populated Medicare patients. Groups are scored out of 110 points on the CMS Web Interface measures. Groups using the CMS Web Interface to submit quality data will submit their Improvement Activities and Promoting Interoperability measures through one of the other submission mechanisms, as applicable. • **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.

continued

Performance Category	Data Submission Mechanisms
Improvement Activities	• Qualified Registry • QCDR • EHR • Attestation
Promoting Interoperability (formerly Advancing Care Information)	• Qualified Registry • QCDR • EHR • Attestation
Cost	• **Administrative Claims** – Cost measures are evaluated using data submitted through routine billing processes. No data submission action is required for administrative claims.

Where can I find a list of approved Qualified Registries and QCDRs?

The lists of CMS-approved QCDRs for 2018 and CMS-approved qualified registries for 2018 are available in the Quality Payment Program Resource Library.

DATA SUBMISSION & PERFORMANCE CATEGORY

SUBMISSION MECHANISM AND PERFORMANCE CATEGORY - QUALITY

What are the data submission requirements for the Quality performance category?

Within the Quality performance category, most groups will need to select at least six measures to report for the 12-month performance period (January 1 – December 31, 2018). (Please note that groups who register to submit data through the CMS Web Interface must submit data for all 15 measures in the CMS Web Interface.)

Of the 6 quality measures, groups need to select one outcome measure OR a high priority measure if an outcome measure is not available.

Groups are encouraged to select the quality measures that are most appropriate for their practice and patient population.

In group participation, quality measure data (numerators, denominators, etc.) are aggregated across the group when submitting data via qualified registry, QCDR, or EHR. Groups registered for the CMS Web Interface will submit data for their quality measures at the beneficiary level.

Are there different quality measures for each submission mechanism?

Quality measures and their specifications vary by submission mechanism. Visit the QPP website for a list of specific quality measures by submission mechanism.

Submission Mechanism					
Administrative Claims*	**Qualified Registry**	**QCDR**	**EHR**	**CMS Web Interface**	**CMS-Approved Survey Vendor** (labeled as CSV on QPP Measures Tool)
Quality Measures Available For 2018					
1 All Cause Hospital Readmission Measure Specification	**248** 2018 Registry Measure Specifications	All available MIPS measures finalized in the rule, and any outside the finalized measure set that they were approved by CMS to collect and report 2018 QCDR Measure Specifications	**54** 2018 eCQM specifications	**15** (all 15 must be completed under this option) 2018 Web Interface Measure Specifications	**1** (the entire CAHPS for MIPS Survey must be completed) CAHPS for MIPS Survey Fact Sheet

SUBMISSION MECHANISM AND PERFORMANCE CATEGORY - PROMOTING INTEROPERABILITY

CMS is overhauling the Advancing Care Information (ACI) performance category to focus on interoperability, improve flexibility, relieve burden and place emphasis on measures that require the electronic exchange of health information between providers and patients. To better reflect this new focus, we are re-naming the ACI performance category to the "Promoting Interoperability" performance category.

What are the data submission requirements for the Promoting Interoperability (formerly Advancing Care Information) performance category?

In 2018, there are two measure sets for reporting based on the Certified EHR Technology (CEHRT) edition that is being used:

- Promoting Interoperability Objectives and Measures
- 2018 Promoting Interoperability Transition Objectives and Measures

Groups need to submit the data in the CEHRT for their MIPS eligible clinicians to fulfill the **required base score** measures for a minimum of 90 days to earn a score for the Promoting Interoperability performance category. Groups may also submit data on performance score measures and bonus score criteria to earn a higher score.

In group participation, measure data from CEHRT (numerators and denominators) are aggregated across the group for all submission mechanisms.

See Appendix A *in the Promoting Interoperability Fact Sheet for the full list of Promoting Interoperability Measures and 2018 Promoting Interoperability Transition Measures. Detailed guidance outlining each element of each Promoting Interoperability Measures and 2018 Promoting Interoperability Transition Measures can be found in the Promoting Interoperability Measure Specifications.*

How does automatic reweighting of the Promoting Interoperability performance category apply to groups?

The following MIPS eligible clinicians qualify for an automatic reweighting when submitting data individually:

- Hospital-based MIPS eligible clinicians
- Ambulatory Surgical Center (ASC)-based MIPS eligible clinicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Non-patient facing MIPS eligible clinicians

When submitting data as a group for the Promoting Interoperability performance category, the group should combine all their MIPS eligible clinicians' data under one Taxpayer Identification Number (TIN). This includes the data of MIPS eligible clinicians who may qualify for a reweighting of the Promoting Interoperability performance category when submitting data individually.

If these MIPS eligible clinicians submit data as part of a group and have data in the group's certified EHR technology (CEHRT), their data should be included in the group's data submission, and they **will** be scored on the Promoting Interoperability performance category like all other MIPS eligible clinicians in the group.

The Promoting Interoperability performance category will be automatically reweighted for a group if **all** of their MIPS eligible clinicians qualify individually for reweighting based on the clinician types and/or special statuses listed above or if they receive a hardship exception. If any MIPS eligible clinician within the group does not qualify for a reweighting, the group must submit data to CMS.

Reweighting continued

Additionally, groups that are considered to be non-patient facing, meaning that more than 75 percent of the clinicians billing under the group's TIN meet the definition of a non-patient facing individually during the determination period, will qualify for automatic reweighting.

How does the Promoting Interoperability performance category apply to groups with clinicians facing a significant hardship?

If all of the MIPS eligible clinicians in a group face a significant hardship that would qualify for reweighting, the group may submit an application to have their Promoting Interoperability performance category score be reweighted to zero. If approved, the group will have their Promoting Interoperability performance category score reweighted to zero percent and the category weight will be reallocated to the Quality or Improvement Activities performance categories.

If any MIPS eligible clinician within the group does **not** qualify for a significant hardship, the group cannot apply to have their Promoting Interoperability performance category score be reweighted to zero percent and will need to submit data for this category, submitting all available data in the CEHRT for the measures they're reporting.

Note: *A new significant hardship exception was added for small groups (15 or fewer clinicians) and clinicians using decertified EHR technology.*

Are there different measures for each submission mechanism?

Measures do not change for each submission mechanism available under the Promoting Interoperability performance category.

SUBMISSION MECHANISM AND PERFORMANCE CATEGORY - IMPROVEMENT ACTIVITIES

What are the data submission requirements for the Improvement Activities performance category?

Within the Improvement Activities performance category, most groups must submit **between two and four activities** for a minimum of 90 continuous days to obtain the maximum score under the Improvement Activities performance category.

Groups with 15 or fewer clinicians or identified as being in a rural or health professional shortage area must submit **one or two activities** for a minimum of 90 days to obtain the maximum score under the Improvement Activities performance category.

In 2018, 21 new improvement activities were added to the Improvement Activities Inventory, so groups have over 110 improvement activities from which to select.

As in 2017, only one clinician in the group needs to be actively engaged in the improvement activity for the group to attest "Yes" to performing the activity.

Are there different improvement activities for each submission mechanism?

Activities do not change for each submission mechanism under the Improvement Activities performance category.

Note: *While activities do not change for each submission mechanism under the Improvement Activities performance category, not all QCDRs or qualified registries support this performance category. The 2018 QCDR Qualified Posting and 2018 Qualified Registries Qualified Posting indicate which vendor support the Improvement Activities performance category.*

SUBMISSION MECHANISM AND PERFORMANCE CATEGORY - COST

What are the data submission requirements for the Cost performance category?

There are two measures in the Cost performance category for Year 2: the total per capita cost measure and the Medicare Spending per Beneficiary (MSPB) measure. CMS will calculate these measures on behalf of the group using administrative claims data, provided the group meets the case minimums for the measures and a benchmark has been calculated for the measures. Please refer to the Cost measure specifications for additional information.

Are there different measures for each submission mechanism?

The two cost measures will be evaluated via administrative claims; there is no data submission required on the part of the group.

DATA SUBMISSION CHECKLISTS

QCDR Data Submission Mechanism Checklist

Use the checklist below to submit the group's data via QCDR, which can be used for the Quality, Improvement Activities, and Promoting Interoperability performance categories.

Groups will:	Vendors will:
✓ Choose a CMS-approved QCDR.	✓ Ensure they have an appropriate identity management account and role for submission.
✓ Choose measures and/or activities.	✓ Use Medicare Claims to verify TIN and ensure the group's TIN is correct on file submission.
✓ Collect data for the 2018 calendar year and make it available to their QCDR.	✓ Obtain consent of group before submission.
✓ Work directly with a QCDR to submit 2018 data by March 31, 2019.	✓ Submit data in the 2018 specified QPP format or QRDA III format (according to the 2018 QRDA III Implementation Guide) by March 31, 2019.

QUALIFIED REGISTRY DATA SUBMISSION MECHANISM CHECKLIST

Use the checklist below to submit the group's data via qualified registry, which can be used for the Quality, Improvement Activities, and Promoting Interoperability performance categories.

Groups will:	Vendors will:
✓ Choose a CMS-approved qualified registry. ✓ Choose measures and/or activities. ✓ Collect data for the 2018 calendar year and make it available to their qualified registry. ✓ Work directly with a CMS-approved qualified registry to submit 2018 data by March 31, 2019.	✓ Ensure they have an appropriate identity management account and role for submission. ✓ Use Medicare Claims to verify TIN and ensure group's TIN is correct on file submission. ✓ Obtain consent of group before submission. ✓ Submit data in the 2018 specified QPP format or QRDA III format (according to the 2018 QRDA III Implementation Guide) by March 31, 2019.

ELECTRONIC HEALTH RECORD DATA SUBMISSION MECHANISM CHECKLIST

Use the checklist below to submit the group's data via electronic health record (EHR), which can be used for the Quality, Improvement Activities, and Promoting Interoperability performance categories. Groups can submit this data directly or can work with a health IT vendor to submit the data on the group's behalf.

Groups will:

- ✓ Choose measures and/or activities.
- ✓ Collect data for the 2018 calendar year in their certified EHR.
- ✓ Ensure the group has appropriate identity management account and role appropriate for submission if submitting directly or work with a certified EHR vendor to submit 2018 data on their behalf by March 31, 2019.
- ✓ Submit measure data:
  - If the data is exported or extracted from CEHRT, the health IT vendor or third party must be able to indicate this data source; and
  - Transmit the data electronically exported or extracted from the CEHRT to us directly or through a data intermediary in the CMS-specified form and manner.

Vendor will:

- ✓ Ensure they have an appropriate identity management account and role for submission.
- ✓ Use Medicare Claims to verify TIN combination; ensure group's TIN combination is correct on file submission.
- ✓ Obtain consent of group before submission (if applicable).
- ✓ Submit measure data (if applicable):
  - If the data is exported or extracted from CEHRT, the health IT vendor or third party must be able to indicate this data source; and
  - Transmit the data electronically exported or extracted from the CEHRT to us directly or through a data intermediary in the CMS-specified form and manner.

ATTESTATION DATA SUBMISSION MECHANISM CHECKLIST

Use the checklist below to submit the group's data via attestation, which can be used only for the Improvement Activities and Promoting Interoperability performance categories. Groups can complete the attestation(s) themselves, or work with a third-party intermediary to complete the attestation on their behalf.

Groups will:	Vendors will (if applicable):
✓ Choose measures and/or activities for each category depending on your group's MIPS performance period. ✓ Ensure the group has an appropriate identity management account and role for submission. ✓ Report data for the 2018 calendar year by March 31, 2019.	✓ Ensure they have an appropriate identity management account and role for submission. ✓ Obtain consent of group before submission.

CMS WEB INTERFACE DATA SUBMISSION MECHANISM CHECKLIST

Use the checklist below to submit the group's quality measure data via the CMS Web Interface. Note that groups using the CMS Web Interface to submit quality data will report their Improvement Activities and Promoting Interoperability measures through one of the other submission mechanisms, as applicable.

The CMS Web interface is only available for groups with 25 or more clinicians. The group will determine its size based on the number of clinicians billing under the TIN at the time of registration. In order for groups to determine the size of their group, group size would be determined before exclusions (those who are exempt from MIPS participation) are applied. Groups can submit data to the Web Interface directly, or work with a third-party intermediary to assist with data submission.

Groups will:	Vendors will (if applicable):
✓ Register between April 1 and June 30, 2018 by logging into qpp.cms.gov. ✓ Ensure the group has an appropriate identity management account and role appropriate for submission. ✓ Submit data for the 2018 calendar year in early 2019 (the 8-week submission window will fall between January 2, 2019 and March 31, 2019) for assigned beneficiaries either through manual data entry or Excel upload.	✓ Ensure they have an appropriate identity management account and role for submission. ✓ Obtain consent of clinicians in group before submission (if applicable). ✓ In early 2019, submit data for the 2018 calendar year (the 8-week submission window will fall between January 2, 2019 and March 31, 2019).

CAHPS FOR MIPS SURVEY CHECKLIST

Use the checklist below to submit the group's data via CAHPS for MIPS, which can be used for the Quality performance category.

Groups will:

- ✓ Register between April 1 and June 30, 2018 by logging into qpp.cms.gov.
- ✓ Select and authorize a CMS-approved survey vendor (from a list published by CMS) to collect and submit your survey data to CMS.
- ✓ Be responsible for your vendor costs to collect and submit the survey.
- ✓ Monitor your vendor's performance during survey administration.
- ✓ Receive your CAHPS for MIPS survey scores from CMS.

POST-DATA SUBMISSION

How is the group's data scored?

Clinicians have the option to report at the individual or group level. For groups that elect to report at the group level, group performance is assessed and scored at the TIN level across all four MIPS performance categories for the 2018 performance period.

How are payment adjustments applied?

Each MIPS eligible clinician participating in MIPS at the group level will receive a payment adjustment based on the group's performance. For clinicians who submit data as a part of a group AND individually, CMS will take the higher of the two final scores and apply the MIPS payment adjustment associated with it.

When the practice (TIN) participates as a group, any individual (NPI) included in the TIN who is excluded from MIPS because they are not a MIPS eligible clinician type or are identified as a new Medicare-enrolled clinician, a QP, or Partial QP would not receive a MIPS payment adjustment, regardless of their MIPS participation. MIPS eligible clinicians who are below the low-volume threshold as individuals will receive a MIPS payment adjustment when reporting as a group provided no other exclusions apply to them.

Note: *The Bipartisan Budget Act of 2018 included a provision that affects how MIPS payment adjustments will be applied. Beginning with the 2019 payment year (2017 performance period), MIPS payment adjustments will be applied to covered professional services furnished by MIPS eligible clinicians; MIPS payment adjustments will not be applied to payments for Part B items and services that are not covered professional services.*

What happens if a clinician joins our group after 8/31 of the performance period?

For the 2017 performance period, we heard stakeholder concerns regarding clinicians who joined a practice (TIN) between September 1 and December 31, 2017. As we work to address these concerns for 2017, we are also investigating our options for the 2018 performance period. We will update this guide as more information becomes available.

What happens if a clinician leaves our group during the performance period?

When submitting data as a group, your practice will aggregate data from the MIPS eligible clinicians billing under your TIN and submit data on their behalf. This may include data from clinicians who left your practice prior to the end of the performance period. Even though the clinician has left your practice, they will still receive a final score and payment adjustment based on your practice's performance which may follow the clinician to any new practice or new TIN they join for the payment year.

- ✓ If a MIPS eligible clinician worked at your practice (TIN A) in 2018 but joined another practice (TIN B) in 2019, then CMS will use the final score from your practice (TIN A/NPI) to apply the MIPS payment adjustment for the NPI at the new practice (TIN B/NPI) in 2020. The clinician will not "inherit" the payment adjustment earned by the new practice.
- ✓ If a MIPS eligible clinician worked at your practice (TIN A) and another practice (TIN B) in the 2018 performance period but joined a different practice (TIN C) in 2019, then CMS will use the higher final score from either of the 2018 practices (TIN A/NPI or TIN B/NPI) to apply the MIPS payment adjustment for the NPI in the new practice (TIN C/NPI).

Payment Adjustment Scenario

Scenario 1

Dr. Anderson ("NPI") is a MIPS eligible clinician working at Arlington Medical Center ("TIN A"), where she has reassigned her billing rights; she practices here from 2017 through 2020. Arlington Medical Center has their clinicians submit data as individuals. Dr. Anderson submitted data through a Registry and earned a +1% MIPS payment adjustment.

Dr. Anderson also begins working at Arlington County Family Medical ("TIN B") in January 2019, assigning her billing rights to the TIN, and practices there through 2020. This practice submitted data as a group for 2018 and earned a +2% MIPS payment adjustment.

What will Dr. Anderson's payment adjustment be in 2020?

Because she bills under both TINs in 2020, Dr. Anderson will receive a payment adjustment under her TIN A/NPI combination and her TIN B/NPI combination.

Her payment adjustment under her TIN A /NPI combination will be based on her TIN A data submission (+1%).

Why? *A clinician (NPI) included in MIPS under a TIN and who bills to that same TIN in the payment year as she did during the performance period will receive a payment adjustment under that TIN/NPI combination according to the final score earned from data submitted/collected under that TIN.*

Her payment adjustment under her TIN B/NPI combination will ALSO be based on her TIN A data submission (+1%) because this is the most advantageous payment adjustment attributed to her under any TIN/NPI combination.

Why? *A clinician (NPI) who bills to a TIN in the payment year that she did NOT bill to during the performance period will receive the payment adjustment under that TIN/NPI combination based on the most advantageous final score attributed to that NPI under any TIN/NPI combination for the performance period. Clinicians don't "inherit" the payment adjustment of the practice they bill under in the payment year.*

Payment Adjustment Scenario

Scenario 2

Dr. Williams ("NPI") is a MIPS eligible clinician working at Harper Valley Family Medical Center ("TIN A"), where he has reassigned his billing rights; he practices here from 2016 through September 2018. Harper Valley Family Medical Center has their clinicians submit data as individuals. Dr. Williams doesn't submit any data for this practice, and therefore receives a MIPS final score of 0 under this TIN (-5% payment adjustment).

Dr. Williams starts practicing at Krozer Health Clinic ("TIN B") on August 1, 2018, assigning his billing rights to the TIN, and practices there through 2020. This practice submitted data as a group and earns a +4% MIPS payment adjustment.

What will Dr. Williams' payment adjustment be in 2020?

Dr. Williams only bills to TIN B during 2020, so he can only receive a payment adjustment under his TIN B/NPI combination.

His payment adjustment under his TIN B/NPI combination will be based on TIN B's group data submission (+4% payment adjustment).

Why? *A clinician (NPI) included in MIPS under a TIN and who bills to that same TIN in the payment year as he did during the performance period will receive the payment adjustment under that TIN/NPI combination according to the final score earned from data submitted/collected under that TIN.*

Payment Adjustment Scenario

Scenario 3

Dr. Lauder ("NPI") is a MIPS eligible clinician working at Mercy Medical Center ("TIN A"), where he has reassigned his billing rights; he practices here from 2016 through December 2019. Mercy Medical Center has their clinicians submit data as individuals. Dr. Lauder participates with a QCDR for 2018 and earned a +3% payment adjustment.

Dr. Lauder also practices at Maryland Family Health Clinic ("TIN B"), where he has reassigned his billing rights; he practices here from 2016 through September 2018. This practice submitted data as a group for 2018 and earned a neutral (0%) payment adjustment.

In January 2019, Dr. Lauder moves to Falls Road Family Practice ("TIN C"), reassigning his billing rights and practicing here through 2020. TIN C submitted data as a group for 2018 and earned a +4% payment adjustment.

What will Dr. Lauder's payment adjustment be in 2020?

Dr. Lauder only bills to TIN C during 2020, so he can only receive a payment adjustment under his TIN C/NPI combination.

His payment adjustment under his TIN C/NPI combination will be based on his TIN A reporting (+3%) because this is the most advantageous payment adjustment attributed to him under any TIN/NPI combination.

Why? *A clinician (NPI) who bills to a TIN in the payment year that he did NOT bill to during the performance period will receive the payment adjustment under that TIN/NPI combination based on the most advantageous final score attributed to that NPI under any TIN/NPI combination for the performance period. Clinicians don't "inherit" the payment adjustment of the practice they bill under in the payment year.*

Payment Adjustment Scenario

Scenario 4

Dr. Michaels ("NPI") is a MIPS eligible clinician working at Virginia Medical Center ("TIN A"), where she has reassigned her billing rights; she practices here from 2017 through 2020. Virginia Medical Center has their clinicians submit data as individuals. Dr. Michaels submitted data via claims and earned a +1% MIPS payment adjustment.

Dr. Michaels also works at Northern Virginia Family Medical ("TIN B") from 2017 through 2020, assigning her billing rights to the TIN, and practices there through 2020. This practice submitted data as a group and earned a +2% MIPS payment adjustment.

What will Dr. Michaels' payment adjustment be in 2020?

Because she bills under both TINs in 2020, Dr. Michaels will receive a payment adjustment under her TIN A/NPI combination and her TIN B/NPI combination.

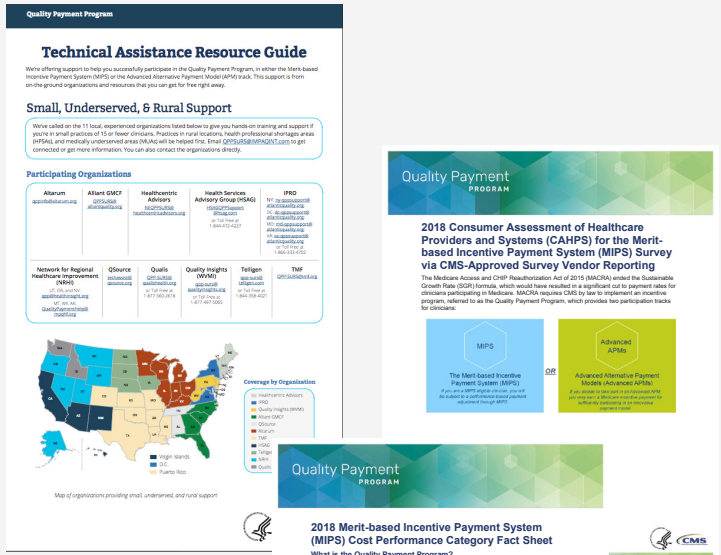
Her payment adjustment under her TIN A /NPI combination will be based on her TIN A data submission (+1%).

Why? *A clinician (NPI) included in MIPS under a TIN and who bills to that same TIN in the payment year as she did during the performance period will receive a payment adjustment under that TIN/NPI combination according to the final score earned from data submitted/collected under that TIN.*

Her payment adjustment under her TIN B/NPI combination will be based on her TIN B data submission (+2%).

Why? *A clinician (NPI) included in MIPS under a TIN and who bills to that same TIN in the payment year as she did during the performance period will receive a payment adjustment under that TIN/NPI combination according to the final score earned from data submitted/collected under that TIN.*

RESOURCES


Quality Payment Program

Technical Assistance Resource Guide

We're offering support to help you successfully participate in the Quality Payment Program, in either the Merit-based Incentive Payment System (MIPS) or the Advanced Alternative Payment Model (APM) track. This support is from on-the-ground organizations and resources that you can get for free right away.

Small, Underserved, & Rural Support

We've called on the 11 local, experienced organizations listed below to give you hands-on training and support if you're in small practices of 15 or fewer clinicians. Practices in rural locations, health professional shortages areas (HPSAs), and medically underserved areas (MUAs) will be helped first. Email QPPSUS@AIMGNT.com to get connected or get more information. You can also contact the organizations directly.

Participating Organizations

Altarum | Alliant GMCF | Healthcentric Advisors | Health Services Advisory Group (HSAG) | IPRO

Network for Regional Healthcare Improvement (NRHI) | QSource | Qualis | Quality Insights (QIWMI) | Telligen | TMF

Coverage by Organization

Map of organizations providing small, underserved, and rural support

Quality Payment
PROGRAM

2018 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for the Merit-based Incentive Payment System (MIPS) Survey via CMS-Approved Survey Vendor Reporting

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. MACRA requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, which provides two participation tracks for clinicians:

MIPS
The Merit-based Incentive Payment System (MIPS)

OR

Advanced APMs
Advanced Alternative Payment Models (Advanced APMs)


Quality Payment
PROGRAM

2018 Merit-based Incentive Payment System (MIPS) Cost Performance Category Fact Sheet

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have made major cuts to payment rates for clinicians participating in Medicare. The law requires us to implement the Quality Payment Program and gives clinicians 2 ways to participate:

MIPS
The Merit-based Incentive Payment System (MIPS)

OR

Advanced APMs
Advanced Alternative Payment Models (Advanced APMs)

Under MIPS, there are 4 performance categories that affect your future Medicare payments. Each performance category is scored by itself and has a specific weight that's its part of the MIPS Final Score. The payment adjustment assessed for MIPS eligible clinicians is based on the Final Score. These are the performance category weights for the 2018 performance period:

Additional Resources

For additional resources, visit the QPP 2018 resource library: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html

Glossary of Terms

APM	CAHPS	CMS	EHR	MIPS	NPI	QCDR	QP	TIN
Alternative Payment Model	Consumer Assessment of Healthcare Providers and Systems	Centers for Medicare & Medicaid Services	Electronic Health Record	Merit-Based Incentive Payment System	National Provider Identifier	Qualified Clinical Data Registry	Qualifying APM Participant	Taxpayer Identification Number