Quality Payment
PROGRAM

2017 Quality Payment Program
Frequently Asked Questions

Please note that questions and answers in this document are only applicable for the 2017 transition year

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Top FAQs

1. What kinds of physicians are considered MIPS eligible clinicians in the Quality Payment Program?

In the Quality Payment Program, a “physician” includes:

- Doctors of Medicine or Osteopathic Medicine
- Doctors of Dental Medicine or Dental Surgery
- Doctors of Podiatric Medicine
- Doctors of Optometry
- Chiropractors

Additionally, Physician Assistants, Clinical Nurse Specialists, Nurse Practitioners, and Certified Registered Nurse Anesthetists are included as MIPS eligible clinicians.

2. Am I still subject to MIPS if I was exempt from Meaningful Use?

MIPS is a separate program from the Electronic Health Record (EHR) Incentive Program. You should first determine your MIPS participation status before you get ready to submit data. Advancing Care Information is just one performance category of MIPS and Certified EHR Technology (CEHRT) is required for data submission. Even if you don’t have CEHRT, you can still participate in MIPS by reporting data in the Quality or Improvement Activities performance categories and avoid a negative payment adjustment. Some clinicians who face hardships with CEHRT may be able to have the Advancing Care Information category excluded from their MIPS score. The hardship exceptions are:

- Insufficient internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over the availability of CEHRT

Applications for hardship exemptions for the transition year of MIPS are available on the Quality Payment Program website.

If you don’t submit data for the Advancing Care Information performance category, you can submit data for the Quality and Improvement Activities performance categories and still perform well in MIPS. You’ll need to submit data on at least one quality measure for 2017 or one improvement activity to avoid a payment adjustment. If you submit additional data, you might get a positive adjustment.

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3. I practice in a rural critical access hospital (CAH) and due to billing assignment I am considered an eligible clinician under MIPS. Do I have to participate?

If you practice in a CAH, you have to participate in MIPS unless you meet one of these exemptions:

- If you practice in a CAH that bills under Method I, the MIPS payment adjustment applies to payments made for items and services that are Part B charges billed by MIPS eligible clinicians. The MIPS payment adjustment wouldn't apply to the CAH's facility payment.
- If you practice in a CAH that bills under Method II and have assigned your billing rights to the CAH, the MIPS payment adjustment applies to the Method II CAH payments.

If you practice in a CAH that bills under Method II and haven't assigned your billing rights to that CAH, the MIPS payment adjustment applies to payments made for items and services that are Part B charges billed by MIPS eligible clinicians. The MIPS payment adjustment wouldn't apply to the CAH's facility payment. This means that if you're a MIPS eligible clinician with Part B charges outside/not assigned to the CAH, you're expected to participate in MIPS.

4. Are professional services given in a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) included in the APM Incentive Payments?

No, professional services given in RHCs and FQHCs aren't paid under the physician fee schedule, so the APM Incentive Payment isn't based on those services. If you also practice in other settings aside from RHCs and FQHCs, the APM Incentive Payment might include your billing under the PFS from the other settings.

5. I work in a FQHC. Can I participate in MIPS?

At this time, FQHCs (as a facility) aren't able to participate in MIPS. However, if you practice in an FQHC, the MIPS payment adjustment applies to payments made for items and services that are Part B charges billed by MIPS eligible clinicians outside/not assigned to the FQHC. This means if you're a MIPS eligible clinician with Part B charges outside/not assigned to the FQHC, you're expected to participate in MIPS.

6. Does my EHR need to be certified to participate in MIPS?

If you're a MIPS eligible clinician, you'll need to have 2014 and/or 2015 Edition CEHRT for the 2017 MIPS performance period. The CEHRT edition helps identify which Advancing Care Information performance category measures you submit. The Advancing Care Information objectives and measures can be reported if your CEHRT is

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certified to the 2015 Edition or a combination of the 2014 and 2015 Editions that support these measures.

Keep in mind, MIPS is flexible. If you don't have CEHRT, you can submit quality measures and improvement activities and still perform well in MIPS overall.

7. What are my "Pick Your Pace" options?

You have some flexibility in the Quality Payment Program. In 2017, there are three 'Pick Your Pace' options: test, partial pace, and full pace. You can also choose not to participate in MIPS.

Here are the "Pick Your Pace" details:

Test Participation: For the 2017 transition year, all MIPS eligible clinicians have a "test" option. If you choose this option, all you have to do is submit a minimum amount of 2017 data, such as one measure under the Quality category or one activity in the Improvement Activities category, which meet minimum program requirements. If you choose the test option, you'll avoid a negative payment adjustment in 2019.

Partial Participation: If you were not ready to start collecting your performance data on January 1, 2017, you can choose to start any time before October 2, 2017. Whenever you choose to start, you'll need to send your performance data to Medicare between January 1 - March 31, 2018, depending on your chosen data submission option. If you choose to partially participate, you should submit a minimum of 90 continuous days of 2017 data for the required number of measures and activities in the Quality, Improvement Activities, and Advancing Care Information performance categories to get a higher performance score, which could allow you to and earn a neutral or small positive payment adjustment. The 2019 MIPS payment adjustment won't be based on the Cost performance category.

Full Participation: For full participation, you had to start collecting your performance data on January 1, 2017. You'll need to submit data from January 1, 2017, to December 31, 2017 (the entire year) for the required number of measures and activities in the Quality, Improvement Activities, and Advancing Care Information performance categories. This data may help you earn a higher performance score, which could allow you to earn a neutral or small positive payment adjustment.

If you report a year's worth of data, your data is likely to be more reliable and you may be more able to get bonus points. This means a better chance to get higher scores.

If you don't participate or submit any data for 2017, then your MIPS final score will be zero points and you'll receive a negative 4% reduction to your 2019 Medicare Part B payments.

Learn more at qpp.cms.gov.

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8. For the transition year, what flexibilities are available for small groups, non-patient facing clinicians and/or clinicians located in a rural area or a Health Professional Shortage Area (HPSA)?

For groups with 15 or fewer clinicians, non-patient facing clinicians, and/or clinicians located in a rural area or HPSA there are flexibilities.

The Improvement Activities performance category is weighted either medium or high. To achieve the maximum 40 points for the Improvement Activity score, you may select either of these combinations:

- one high-weighted activity
- two medium-weighted activities

Each medium-weighted activity is worth 20 points of the total Improvement Activity performance category score, and a high-weighted activity is worth 40 points of the total category score. You may select two medium-weighted activities or one high-weighted activity to receive a total of 40 points of the total category score.

If you're in a certified patient-centered medical home or an APM designated as a medical home model, you'll automatically receive full credit in this category.

If you're in a MIPS APM and on the APM Participant List on one of the three snapshot dates (March 31, June 30 or August 31) you'll receive full credit for this category unless you're excluded from MIPS because you're a qualifying participant (QP) in an Advanced APM. MIPS eligible clinicians may receive half credit for this category when they report they're in another APM if they're also on our APM Participant List.

9. Our practice is a member of two different Shared Savings Program Track 1 Accountable Care Organizations (ACOs). Do we have to report data under MIPS as part of a MIPS APM, or can we report as a group directly to you?

The Shared Savings Program Track 1 is a MIPS APM. If you participate in MIPS APMs, you'll be scored using the APM scoring standard instead of the generally applicable MIPS scoring standard. Your data will be included in both Track 1 ACOs. Your TIN/NPI will receive the highest of the two MIPS APM scores.

To be scored as a MIPS eligible clinician participating in a MIPS APM, you must be listed on the Shared Savings Participant List on at least one of the three snapshot dates, March 31, June 30, or August 31. If you're not listed on the Shared Savings Program Participant List on at least one of these dates, you'll need to report to MIPS according to all applicable MIPS reporting and scoring requirements. So, in this case, you must be listed on the Participant List of both Track 1 ACOs.

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If you participate in Shared Savings Program Track 1 ACOs, your final score is assessed across 3 categories for the ACO.

- Quality: ACOs in the Shared Savings Program submit quality measures to the CMS Web Interface for their participating providers and MIPS eligible clinicians. As long as your ACO submits all of the required Shared Savings Program Web Interface measures, then you don't need to report the MIPS Quality performance category separately. This performance category weight is 50% of the ACO's final score.
- Cost: Your ACO won't be assessed on this category. This performance category weight is 0% of the ACO's final score.
- Improvement Activities: We've assigned improvement points to Shared Savings Program ACOs. For the 2017 performance year, the points exceed the maximum reporting requirements for this category. So, if you're billing through ACO participant TINs, there's no need to report additional activities for this category. If you are in two Shared Savings ACOs, both Shared Savings ACOs will receive the maximum points for this category. You'll receive the maximum amount of points for this category, which is weighted at 20% of the ACO's final score.
- Advancing Care Information: Each ACO participant TIN is responsible for submitting data on the Advancing Care Information category as specified by MIPS. Performance on this category is assessed by calculating the weighted mean of the ACO participant TIN scores in this category. This performance category weight is 30% of the ACO's final score. All Shared Savings Program ACO participant TINs must report the ACI category to meet the Shared Savings Program requirement for the Certified EHR Use Measure ACO #11. The Shared Savings Program participant TINs report this category according to the MIPS group reporting requirements.

10. Should I participate in MIPS individually or as a group?

Each clinician and/or practice will have to figure out whether it's best for them to participate in MIPS individually or as a group.

To participate as a group, you submit data at the TIN-level across all of the MIPS performance categories. If you participate individually, you'll submit data at the TIN/NPI-level across the MIPS all of performance categories.

To report as a group:

- There have to be two or more clinicians in the group
- At least one has to be a MIPS eligible clinician
- All the eligible clinicians bill Medicare through a single TIN, no matter their specialties or practice sites

Geographic location of eligible clinicians isn't important if participating as a group, but they're required to participate under the same TIN. There are flexibilities for eligible clinicians practicing in small groups, non-patient facing clinicians, and/or clinicians located in a rural area or HPSA.

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To learn more, see the Support and Available Options for Small, Underserved, and Rural Practices web page on the qpp.cms.gov.

Here's a checklist to help you to know if participating as a group is right for you:

- Geographic location aside, do you have at least two clinicians under a single TIN?

  If yes, are at least one of the clinicians a MIPS eligible clinician (Physicians (MD/DO and DMD/DDS), Physician Assistants, Clinical Nurse Specialists, Nurse Practitioners, and Certified Registered Nurse Anesthetists)?

- Together, do you and the clinicians in your group, under the same TIN, meet the low-volume threshold? Do you collectively bill more than $30,000 in Part B allowed charges AND provide care for more than 100 Medicare Part B patients during the same period meet the threshold?

  If you answered yes to these questions, group participation may be an option for your practice. If you mostly answered "no", you should consider participating individually.

11. How can I go from MIPS to an Advanced APM?

One way to move from MIPS to an Advanced APM is to participate in any type of APM model in order to get used to a new way to deliver care to patients. Even if you participate in an Advanced APM and don't meet requirements to be a Qualifying APM Participant and earn the 5% incentive payment, you'll be participating in an APM and potentially scored under MIPS using the special APM scoring standard if the APM meets the criteria to be a MIPS APM. At first, you can participate and learn over time how to meet Advanced APM requirements as your practice moves toward value-based models.

12. For auditing purposes, how long should I keep documentation?

The Quality Payment Program Final Rule with comment requires us to give the criteria we'll use to audit and validate measures and activities for the transition year of MIPS for the Quality, Advancing Care Information, and Improvement Activities performance categories.

The False Claims Act encourages you to keep documentation up to 10 years and, as stated in the final rule, we may request any records or data you've kept for MIPS, for up to six years.

The 2017 data validation and auditing criteria can be found at here.

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Participation

13. Who is considered a non-patient facing clinician?

To be a non-patient facing clinician, you:

- Bill for 100 patient-facing encounters or less, including Medicare telehealth services, during the non-patient facing determination period.
- Have a group where more than 75% of the NPIs billing under the groups TIN bill for 100 patient-facing encounters or less, including Medicare telehealth services, during the non-patient facing determination period.

14. I saw 81 patients and interpreted scan results (a non-patient facing activity) for more than 100 patients last year. Am I subject to MIPS or do I meet the low-volume exclusion?

If you bill Medicare more than $30,000 in Part B allowed charges and care for more than 100 Part B patients during the applicable determination period, you're subject to MIPS. If you don't exceed both of these thresholds, you're exempt for the applicable year as an individual. If your group meets these requirements, then you are included in MIPS if the practice decides to report as a group.

We'll decide if you meet the low-volume threshold exclusion based on the total number of Medicare Part B patients you gave services to during the applicable determination period. It doesn't matter whether you've providing patient-facing or non-patient facing care for the purpose of the low-volume exception. Because you provide services to more than 100 Part B patients over the determination period, you're not excluded from MIPS if you also bill more than $30,000 in Part B allowed charges during the same period. But, if more than 75% of your Medicare services are non-patient facing, you'll have different requirements under MIPS.

15. When will you send out MIPS Eligibility/Exclusions letters?

In April and early May 2017, we sent notification letters out to you to let you know about your basic Quality Payment Program participation status. Your letter should've come from your Medicare Administrative Contractors (MACs) around the end of April or beginning of May.

We also released a new participation look-up tool on qpp.cms.gov in spring 2017. This new tool lets you search your participation status with your National Provider Identifier (NPI).

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16. If I work only in an urgent care center owned by a health-system, am I hospital-based? If so, am I subject to MIPS?

A hospital-based MIPS eligible clinician is a clinician who gives 75% or more of their covered professional services in an inpatient hospital, on-campus outpatient hospital, or emergency room setting (as identified by Place of Service (POS) codes 21, 22, and 23) during a period before the 2017 performance period.

Urgent care centers aren't included in the definition of hospital-based, so if you work primarily in an urgent care center, you're not considered hospital-based, even if the urgent care center is owned by a hospital.

If you're hospital-based, you'll be subject to MIPS and should submit data for the Quality and Improvement Activities performance categories. Hospital-based MIPS eligible clinicians may qualify for reweighting of the Advancing Care Information performance category to 0% of their MIPS final score if there aren't enough measures available or applicable to the clinician. The Advancing Care Information performance category weight (25% for the transition year) would be reallocated to the Quality performance category.

17. If my practice is 95% hospital based, am I still subject to MIPS?

You're a hospital-based MIPS eligible clinician if you furnish 75% or more of your covered professional services in an inpatient hospital, hospital outpatient location on campus, or an emergency department based on your claims from a past period of our choosing.

Even if you qualify as hospital-based, you're still subject to MIPS and have to report data in the Quality and Improvement Activities performance categories. If you're a hospital-based MIPS eligible clinician, you may qualify to have the Advancing Care Information performance category reweighted to 0% of your MIPS final score. The Advancing Care Information performance category weight would be reallocated to the Quality performance category. Cost category isn't measured in the first year of the program.

18. What's included in the $30,000 low-volume threshold? Is it allowed charges only or are lab charges included?

For the 2017 performance period, the low-volume threshold is based on Medicare Part B allowed charges less than or equal to $30,000 that are charged during the applicable determination period and apply to fewer than 100 Medicare beneficiaries.

If you report as an individual, the low-volume threshold exclusion will be applied at the individual clinician (NPI/TIN) level. If your practice chooses group reporting, the low-volume threshold exclusion will be applied at the group (TIN) level. You may qualify for the exclusion at the individual (TIN/NPI) level, but if you're part of a group that doesn't meet the criteria, you'll have to participate in MIPS as part of the group.

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19. Do eligible clinicians working at independent diagnostic testing facilities (IDTFs) or independent laboratories need to participate in MIPS in 2017?

The MIPS payment adjustment applies to Medicare Part B items and services furnished by a MIPS eligible clinician at the TIN/NPI level. Since facilities aren't eligible to participate, services billed under an IDTF or an independent laboratory aren't eligible for MIPS. However, Medicare Part B services billed outside of an IDTF or independent laboratory by eligible clinicians (using a TIN/NPI combination) are eligible for MIPS.

Suppliers of IDTF services (such as a portable X-ray company) and independent laboratories aren't included in the definition of a MIPS eligible clinician or required to participate. There may be times when a MIPS eligible clinician would furnish the professional part of a Part B covered service that's billed by a supplier. Right now, we're not able to use those services for payment determination.

20. What dates did Medicare use to determine low-volume threshold and will there be a 2nd data run?

CMS reviewed your historical Medicare Part B claims data form 9/1/15 to 8/31/15 to make your initial determination and conducted a second determination on performance period Medicare Part B claims from 9/1/16 to 8/31/17. If you were included in the first determination, you may be reclassified as exempt for performance year 2017 during the second determination. If you were initially exempt and later found to have claims/ patients exceeding the low-volume threshold, you are still exempt.

Check your participation status here.

21. Why is my contact information on the NPI lookup tool wrong?

The address shown on the MIPS Participation Look-Up Tool is from data pulled on December 16, 2016. The address displayed does not impact participation. If you would like to update your contact information, please do so by contacting PECOS at (pecos.cms.hhs.gov) and update the correct information. The next time we capture data, which will be at the end of this year, you should see the updated information.

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Pick Your Pace

22. I'm in a 2 physician multi-specialty practice, and both physicians bill under the same TIN with separate NPIs. In past years for MU, we reported individually. Can we still report individually under MIPS or do we have to report as a group?

Both physicians in your practice can still report individually under MIPS. Group practices don't have to report as a group just because there are multiple MIPS eligible clinicians billing under the same TIN. Each practice decides whether its members will report as an individual or as a group.

When reporting individually, each physician in the practice is assessed at the TIN/NPI-level across the MIPS performance categories.

To be assessed as a group, physicians report at the TIN-level across the MIPS performance categories. If participating in MIPS as a group, the physicians jointly report their measures and activities data for all performance categories. Generally, they'll earn the same performance score.

23. If I'm the only person in my practice under one TIN, but registered as a group with Medicare, do I participate in MIPS as an individual or as a group?

If your practice has only one MIPS eligible clinician under one TIN, then you have the option to participate for the 2017 performance period as an individual or group. To report as a group for 2017, the group must have two or more clinicians where at least one has to be a MIPS eligible clinician.

24. How many quality measures do eligible clinicians need to report? Do I have to report an outcome measure?

To participate at the full pace, most MIPS eligible clinicians will need to report data on at least six quality measures. One of the six measures has to be an outcome measure. If there isn't an outcome measure that applies to your practice, then you'll need to choose another high-priority measure. If fewer than six measures apply to your practice, then report on all measures that do apply. Reporting on at least one quality measure exempts you from a negative payment adjustment for the transition year. If you submit more than one measure, but less than six for 90 days or more, we'll take a look and you may be able to earn a positive payment adjustment.

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25. Do I have to register with you to report data under MIPS?

You don't have to register to report data under MIPS unless you're reporting data via our Web Interface (a data submission option only available for groups of 25 or more eligible clinicians) or the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey for the Quality performance category. In other cases, when you submit data, either through Medicare Part B claims, CEHRT, qualified registry, QCDR, or attestation (Improvement Activities or Advancing Care Information performance categories), you're demonstrating your participation in MIPS. No registration is required!

Please see the "What are my 'Pick Your Pace' options?" in the participation section for 2017 program requirements to get started.

For the Advancing Care Information performance category, you'll need to report that you met the base five required measures for a minimum of 90 continuous days. You can report optional measures for additional credit.

More information on reporting measures for each of the performance categories can be found under the "Explore Measures" tab on qpp.cms.gov.

26. If I plan to participate in MIPS using claims-based reporting of quality measures data for a 90-day period in 2017, do I have to let you know when the 90-day period starts? Do you assume that the 90-day period starts on the date I start putting reporting codes on the claims data? What if I want to do longer than a 90-day period for claims?

You don't have to tell us your participation pace or when you start your 90-day reporting period. Just submit your claims data for a minimum of 90 consecutive days, either through the year or during the data submission period beginning on January 2, 2018, for the Quality performance category. You must start collecting data/appending quality data codes to your claims no later than October 2, 2017, so that you can collect data for 90 consecutive days in 2017. We encourage you to work with your Medicare Administrative Contractor (MAC) to determine exactly when your claims are needed to ensure they are processed by March 1, 2018.

If you're reporting your quality measures data via claims, beyond the test option, you need to meet the data completeness requirements to get more than the minimum three points for submitting any data. This means:

- For each measure, you must have enough case volume (≥ 20 cases for most measures).
- You must report on at least 50% of the Medicare Part B patients you saw during the performance period that applies to the quality measure.

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If you want to report for longer than a 90-day period, we will use the first QDC or G-code that is received on your claims as the start of your performance period.

27. If I participate in both Medicaid and Medicare, does my participation in the Medicaid EHR Incentive Program affect how I report advancing care information measures under MIPS?

The MIPS payment adjustment applies to Medicare Part B items and services furnished by MIPS eligible clinicians during the applicable year. MIPS doesn't replace the Medicaid EHR Incentive Program (or the Medicare EHR Incentive Program for Eligible Hospitals), which continues through program year 2021. If you're eligible for the Medicaid EHR Incentive Program, you'll continue to attest to your State Medicaid Agency to get incentive payments. If you're also subject to MIPS, you can attest directly to us to report advancing care information measures.

28. I'm an ESRD Seamless Care Organization (ESCO) participant. What are my reporting requirements?

If you're an ESCO participant, you're in the Comprehensive ESRD Care (CEC) Model. The two-sided risk tracks (Large Dialysis Organization Arrangement and Non-Large Dialysis Organization Two-Sided Risk Arrangement) of the CEC Model are Advanced APMs. Like participants in all Advanced APMs, eligible clinicians in these CEC two-sided risk tracks will be assessed for QP status. If you're in the APM entity (ESCO) and meet the QP thresholds, you'll be excluded from MIPS and will earn a 5% lump sum incentive payment. If you're in the CEC (Two-Sided Risk) Model and don't meet the thresholds to become a QP or Partial QP, you'll report according to the APM scoring standard for MIPS APMs (below). To receive the special reporting and scoring under the APM scoring standard, your TIN/NPI must be included on the CEC Participant List on at least one of the three snapshot dates: March 31, June 30, and August 31. If you're not included on the CEC Participant List on one of these three dates, you should report to MIPS as an individual or as a group according to all applicable MIPS reporting and scoring requirements.

The one-sided risk track (Non-Large Dialysis Organization One-Sided Risk Arrangement) of the CEC Model isn't an Advanced APM. If you're in the APM Entity group with the ESCO in the non-Advanced APM tracks of CEC (One-Sided Risk), you'll report under MIPS as a MIPS APM and get special scoring under the APM scoring standard provided you're on the CEC APM Participant List on at least one of the three snapshot dates: March 31, June 30, or August 31.

1. You won't be assessed on the Quality performance category under MIPS in the first performance period. The APM Entity (ESCO) will submit quality measures to us as required by the terms of their participation in the CEC Model.

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2. You won't be assessed on the Cost performance category under MIPS.
3. We've assigned improvement activity points to the CEC ESCOs. For the 2017 performance year, the points exceed the maximum available points for this category. You don't have to report additional activities for this category.
4. Each MIPS eligible clinician in the MIPS APM reports advancing care information data through either group reporting at the TIN level or individual reporting according to all MIPS requirements for ACI.

29. If a practice participates in the Oncology Care Model APM, can the eligible clinicians in the practice submit data as a group or as an individual?

The Two-Sided Risk Arrangement of the Oncology Care Model (OCM) Model is an Advanced APM for 2017. As with all participants in Advanced APMs, if you participate in the OCM (Two-Sided Risk) Arrangement, you'll be assessed for QP status. If you're a participant in the APM Entity and meet the QP thresholds, you'll be excluded from MIPS and will earn a 5% lump sum incentive payment. If you're a participant in the APM Entity and don't meet the thresholds to become a QP or Partial QP, you'll report according to the APM scoring standard for MIPS APMs (below). If you meet the slightly lower thresholds to become a Partial QP, you'll be able to choose whether to participate in MIPS. If you're a Partial QP and choose to participate in MIPS, you'll report according to the APM scoring standard for MIPS APMs (below). To be included in the special reporting and scoring under the APM scoring standard, your TIN/NPI must be included on the OCM Participant List on at least one of the three snapshot dates: March 31, June 30, and August 31. If you're not included on the OCM Participant List on at least one of these three dates, you should report to MIPS as an individual or as a group according to all applicable MIPS reporting and scoring requirements.

The One-Sided Risk Arrangement of the OCM isn't an Advanced APM. If you participate in the OCM One-Sided Risk Arrangement, you'll report under MIPS and get special MIPS scoring under the APM scoring standard if you're on the OCM Participant List on at least one of the three snapshot dates: March 31, June 30, or August 31. If you're not on the OCM Participant List on one of the snapshot dates you should report to MIPS as an individual or group according to all applicable MIPS reporting and scoring requirements.

1. You won't be assessed on the Quality performance category under MIPS in the first performance period. The APM Entity (OCM practice) will submit quality measures to us as required under the terms of the APM.
2. If you're in the APM Entity (OCM practice), you won't be assessed on cost.
3. We've assigned improvement activity points to OCM participants. For the 2017 performance year, the points exceed the maximum available points for this category. You don't need to report additional activities for this category.

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4. Each MIPS eligible clinician in the APM Entity reports advancing care information data through either group reporting at the TIN level or individual reporting according to all ACI requirements.

30. If our practice is a certified patient-centered medical home, do we have to report improvement activities?

You get full credit for the Improvement Activities performance category if you're practicing in a certified patient-centered medical home, including Medical Homes Model, or a comparable specialty practice. For multi-practice groups, if only one group is certified as a Patient-Centered Medical Home, the entire group (under the same Taxpayer Identification Number (TIN)) can still get full credit.

31. What's the payment adjustment difference if we report for 90 days vs. a full year in Pick Your Pace?

We'll evaluate your performance based on the data you submit, no matter whether the timeframe is one, 45, or 200 days or more. You'll meet the minimum program requirement if you just submit one quality measure or one improvement activity once. If you do more, you can expect at least a small positive payment adjustment. Generally, the more data you submit, the greater your chance to receive a higher positive payment adjustment.

32. Do I have to submit for a full year to get the MIPS exceptional performance bonus?

No, we base the bonus on all of the data you submit, even if it isn't from a full year. In order to potentially receive the exceptional performance bonus, you'll need to fully participate in more than one performance category. You'll also have the best chance to show you have high performance by participating for a year or as close as possible to a year.

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MIPS Performance Categories

33. What ways can I submit quality measures data?

As an individual, you can submit your quality measures via:

- Qualified Clinical Data Registry (QCDR)
- Qualified Registry
- EHR
- Claims

Groups can submit their quality measures via:

- Qualified Clinical Data Registry (QCDR)
- Qualified Registry
- EHR
- CMS Web Interface (groups of 25 or more)
- CAHPS for MIPS Survey
- Administrative Claims

34. Where can I find quality measures and codes for MIPS? Should I use the same measures I used in PQRS?

While many of the MIPS quality measures are the same as the PQRS measures, it's important to look at the measures and their specifications so you can submit your data correctly. You should review your patient population and choose the MIPS quality measures that are best for you and/or your group.

You can find the measures, their specifications, and how to report at https://qpp.cms.gov/about/resource-library.

35. Where can I find a list and description of Improvement Activities?

You can find descriptions of improvement activities and how they may be performed in drop down boxes under the activities listed at: https://qpp.cms.gov/mips/improvement-activities. To meet improvement activity requirements under MIPS, you should attest either directly to us or through a third party intermediary such as CEHRT, qualified registries, or QCDRs, that are submitting on your behalf. For the 2017 transition year, you'll provide a yes/no answer for the activities listed on the improvement activities inventory.

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36. What are the different ways I can submit MIPS data to you by performance category?

If you're participating individually or as a group, you can submit data in one of these ways:

- **Quality performance category**: Claims (individuals only), qualified registry, QCDR, or CEHRT
- **Cost performance category**: no submission required
- **Improvement Activities performance category:** Attestation, qualified registry, QCDR, or CEHRT
- **Advancing Care Information performance category**: Attestation, qualified registry, QCDR, or CEHRT

In addition, if you're reporting as a group you can submit in one of these ways:

- **Quality performance category**: Administrative claims, CMS Web Interface (for groups of 25 or more eligible clinicians) or CMS-approved vendor for the CAHPS for MIPS Survey
- **Improvement Activities and Advancing Care Information** performance categories: CMS Web Interface

Eligible clinicians can select different data submission mechanisms for each performance category, but should only use one mechanism per category.

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Payment Adjustments

37. There aren't enough Advancing Care Information measures for our specialty. What should we do to be successful? If we electronically submit our quality measures, will we be incentivized?

We encourage you to report electronically. As an incentive, one bonus point is available for each quality measure submitted from your CEHRT directly to us, QCDR or Qualified Registry known as *end-to-end* electronic reporting.

If we don't have Advancing Care Information measures applicable or available for you but you have CEHRT, you may qualify for the end-to-end bonus.

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Group Participation

38. Does every clinician participating in a group need to submit MIPS data or can one clinician submit data for the whole group?

Participating as a group requires one submission for the group at the TIN level. This means that a representative of the group submits the required MIPS data for all the eligible clinicians under a TIN.

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Data Submission

39. What happens if I submit MIPS data individually and as a part of a group?

In instances where we receive individual and group-level data from eligible clinicians, we'll assign the highest score to that clinician.

If you submit as a part of your group and individually, it's possible that your payment adjustment might be different from your colleagues in your group.

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