Quality Payment
PROGRAM

AN INTRODUCTION TO:

The Merit-based Incentive Payment System (MIPS) in 2017

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How to Use This Guide

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Hyperlinks

Hyperlinks to our Quality Payment Program website are included throughout the guide to direct you to more information and resources.

Resources

This guide includes an icon to let you know there are more resources on the topic you're reading about.

Please note: *This guide was prepared as a service to the health care industry 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 either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.*

PROGRAM OVERVIEW

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What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program (QPP), that provides for **two participation tracks:**

Merit-based Incentive Payment System MIPS	**Advanced Alternative Payment Models** APMs
You may receive a performance-based payment adjustment for providing evidence-based and practice-specific quality care supported by technology and reporting on your progress.	These are innovative payment models; if you decide to participate in one through Medicare Part B, you may earn an incentive payment.

The Quality Payment Program takes a comprehensive approach to payment. Instead of basing payment only on a series of billing codes, the Quality Payment Program adds consideration of quality through a set of evidenced-based measures that were primarily developed by clinicians. The program recognizes and encourages improvements in clinical practice. All of these efforts are increasingly supported by advances in technology that allow for the easy exchange of needed information while protecting patient privacy. The program provides special provisions for those participating in certain new models of care that provide an alternative to fee-for-service.

Please note that this guide focuses on the MIPS track. For more information on how to participate in APMs, visit the QPP page of the CMS.gov. Additionally, clinicians participating in a MIPS APM should refer to the MIPS APMs fact sheet for more information.

What is MIPS?

MIPS is 1 of 2 tracks of the Quality Payment Program. MIPS combines 3 Medicare "legacy" programs – the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and the Medicare EHR Incentive Program for Eligible Professionals – into a single program.

Under MIPS, there are 4 performance categories that will affect your Medicare payments:			
Quality	Cost	Improvement Activities	Advancing Care Information

Calendar Years 2016 (for the PQRS and VM programs) and 2017 (for the Medicare EHR Incentive Program for Eligible Professionals) were the final reporting years for these programs, while 2018 is the last year clinicians may receive a payment adjustment under these legacy programs.

Under MIPS, physicians and other clinicians submit measures and activities focused on quality – that assess evidence-based and specialty-specific standards as well as practice-based improvement activities; cost of services; and the use of certified electronic health record technology (CEHRT) to support interoperability.

Under MIPS

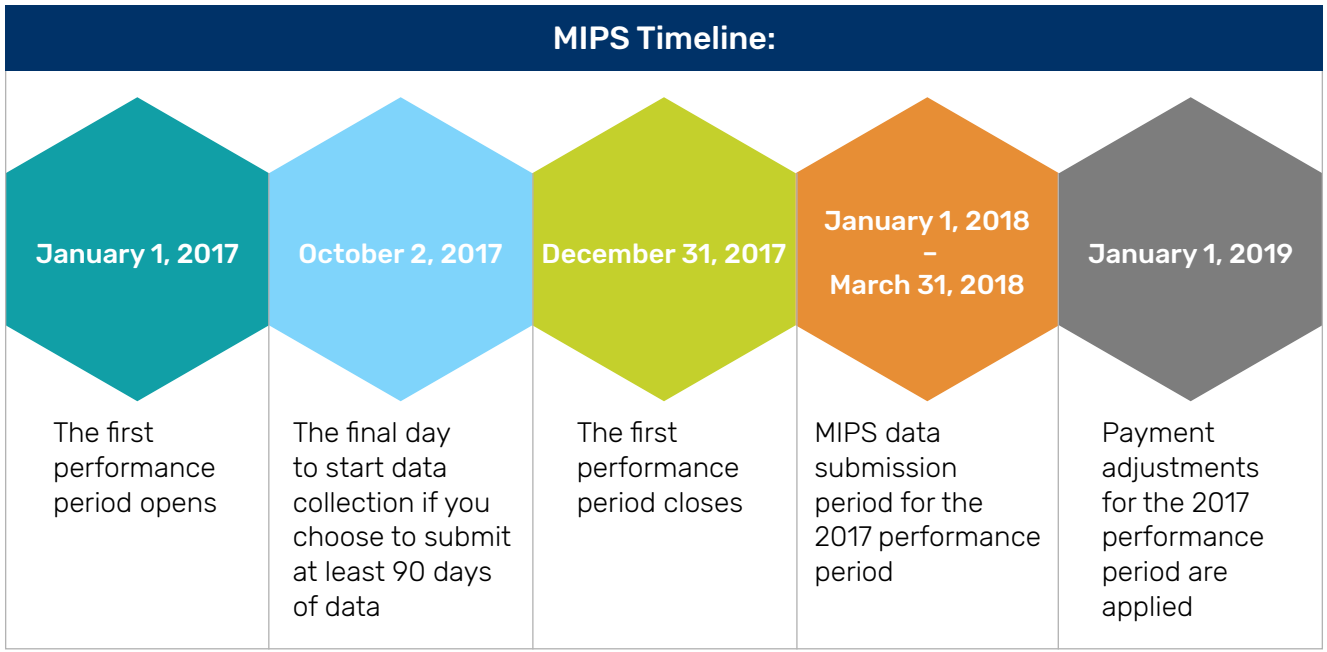
Medicare Part B clinicians that are eligible for MIPS can choose to participate in the MIPS performance-based payment system

For the 2017 transition year, MIPS eligible clinicians can choose the amount of data they submit to ensure CMS is assessing activities and measures that are meaningful to their practice

HOW TO PARTICIPATE

When Does Participation Begin?

The first MIPS performance period for the transition year is January 1, 2017 through December 31, 2017.



Who Can Participate?

CMS describes professionals who are included for participation in MIPS as MIPS eligible clinicians. For the first two years of MIPS (CY 2017 and CY 2018), a MIPS eligible clinician is defined as the following:

Physicians*

Physician Assistants

Nurse Practitioners

Clinical Nurse Specialists

Certified Registered Nurse Anesthetists

***Physicians** (doctors of medicine, doctors of osteopathy, doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors[1])*

Any clinician group that includes one of the professionals listed above

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

Can Clinicians Who Are Not Considered MIPS Eligible Clinicians Still Participate in MIPS?

Clinicians who are not eligible for MIPS now, because they are not in one of the categories listed on the previous page, can participate voluntarily. Voluntary participation allows clinicians to prepare and become familiar with the program in the event that they are included as MIPS eligible clinicians in future years, without any impact of the payment adjustment (neither positive nor negative).

Non-Patient Facing MIPS Eligible Clinicians

CMS defines non-patient facing MIPS eligible clinicians as individual MIPS eligible clinicians who bill 100 or fewer patient-facing encounters (including Medicare telehealth services) during the applicable determination period. Groups are considered non-patient facing if more than 75 percent of their MIPS eligible clinicians have 100 or fewer patient-facing encounters (including Medicare telehealth services) during the applicable determination period. Non-patient facing MIPS eligible clinicians and groups are required to participate in MIPS and have alternative requirements for the Advancing Care Information and Improvement Activities performance categories.

MIPS Eligible Clinicians in MIPS APMs

If clinicians are in a specific type of Alternative Payment Model called a MIPS APM, they may participate in MIPS through that APM and be scored using what is called the APM scoring standard. This APM scoring standard is designed to account for activities already required by the APM and eliminates the need for clinicians to duplicate the submission of certain quality and improvement activities data described later in this guide.

Who is Excluded?

Clinician types that are not included in the general definition of a MIPS eligible clinician are excluded from the MIPS payment adjustment. In addition, certain clinicians who would otherwise be considered MIPS eligible clinicians may not be included in MIPS if they are a MIPS eligible clinician who meets the criteria for one of three exclusions, then the MIPS eligible clinician would be excluded from the MIPS payment adjustment.

1	Clinicians who enroll in Medicare for the first time during a MIPS performance period are exempt from reporting on measures and activities for MIPS until the following performance period.
2	Qualifying APM Participants (QPs) are not considered MIPS eligible clinicians and are excluded from the MIPS payment adjustment. Partial QPs who do not report on measures and activities that are required to be reported under MIPS for a given performance period for a year are not considered MIPS eligible clinicians and are excluded from the MIPS payment adjustment.
3	MIPS eligible clinicians or groups, that during the applicable determination period, do not exceed the low-volume threshold (have Medicare Part B allowed charges less than or equal to $30,000 or provides care for 100 or fewer Part B-enrolled Medicare beneficiaries) are excluded from the MIPS payment adjustment for the performance period with respect to a year. Please note that the low-volume threshold is determined at the Taxpayer Identification Number (TIN)/ National Provider Identifiers (NPI) level for individual eligible clinicians, TIN level for Groups and Entity level for APMs.

What is Pick Your Pace?

The first year of MIPS reporting under the QPP is CY 2017, which will serve as a transition year to help MIPS eligible clinicians prepare for future reporting. During the transition year, MIPS eligible clinicians have the option to "pick your pace" of participation from three different options:

Test	• MIPS eligible clinicians can submit some data after January 1, 2017 to be eligible for a neutral or small positive payment adjustment.
Partial	• MIPS eligible clinicians submit data for a period of 90 consecutive days any time after January 1, 2017. • October 2, 2017 is the last day to begin data collection to submit at least 90 days of data • By submitting at least 90 days of data, MIPS eligible clinicians can be eligible for a positive payment adjustment.
Full	• MIPS eligible clinicians who are prepared to fully participate can do so starting on January 1, 2017. • MIPS eligible clinicians who submit a full year of data may qualify for a somewhat higher positive payment adjustment.

*For 2017, please note that the MIPS payment adjustment is determined by performance across the Quality, Improvement Activities and Advancing Care Information performance categories.

PERFORMANCE CATEGORIES

Under MIPS, there are 4 performance categories that will affect your Medicare payments:

Quality	Cost	Improvement Activities	Advancing Care Information
			
weight	weight	weight	weight

Note: Performance category weights differ for eligible clinicians in MIPS APMs. In this section, we will explain the four performance categories and their requirements for participation.

Performance Category

Quality

60%

The **Quality** performance category is worth 60% of the MIPS final score. The requirements of the Quality category were established to add flexibility for MIPS eligible clinicians to focus on the measures that are important to the quality of care in their practice and important to their patients.

Reporting Requirements for 2017

Test:

- Choosing the test option means that clinicians submit the minimally required data of one quality measure, for one patient for one day. This will let clinicians become familiar with the program while making sure they avoid the negative payment adjustment.

Partial:

- Submitting at least six quality measures, including at least one outcome measure, for 90 days or up to a full year. Under partial participation, CMS will analyze performance data, and clinicians have the chance to earn a modest positive payment adjustment.

Full:

- Full participation requires submitting data for the full year (Jan 1-Dec 31, 2017). Participating fully gives clinicians a greater chance to receive a higher positive payment adjustment.

For 2017, please note that the MIPS payment adjustment is determined by performance across the Quality, Improvement Activities, and Advancing Care Information performance categories.

continued

Performance Category

Cost

The **Cost** performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine payment adjustments. Therefore, the cost performance category is worth 0% of a MIPS eligible clinician's final score for the first performance period under MIPS.

Certain measures for MIPS eligible clinicians, including specific episode measures, will be calculated using cost based on administrative claims data, including specific episode measures, for Medicare patients only and only for patients that are attributed to them. Therefore, there are no submission requirements other than claims submission necessary under this category for clinicians.

Improvement Activities

The **Improvement Activities** performance category assesses how much a MIPS eligible clinician participates in activities that improve clinical practice. **This performance category is worth 15% of the MIPS eligible clinician's final score.**

MIPS eligible clinicians will have the flexibility to choose from approximately 90 activities under 9 subcategories (categorized as either high-weighted or medium-weighted):

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

continued

Performance Category

Improvement Activities

Reporting Requirements for 2017

The following are the different options under the "Pick Your Pace" approach adopted in the 2017 transition year of MIPS:

Test:

- Submit 1 improvement activity to avoid a negative payment adjustment.
- Activity may be high-weighted or medium-weighted.

Partial or Full:

- Choose 1 of the following combinations for a minimum of 90 consecutive days to qualify for a positive payment adjustment:
  - 2 high-weighted activities.
  - 1 high-weighted activity and 2 medium-weighted activities.
  - At least 4 medium-weighted activities.

Flexibilities:

- **Groups with 15 or fewer clinicians, non-patient facing MIPS eligible clinicians, or clinicians in a rural or health professional shortage area:** Attest that you completed up to 2 activities of any weight for a minimum of 90 consecutive days.

For 2017, please note that the MIPS payment adjustment is determined by performance across the Quality, Improvement Activities, and Advancing Care Information performance categories.

continued

Performance Category

Advancing Care Information

25%

The **Advancing Care Information** performance category promotes patient engagement and the electronic exchange of health information using certified EHR technology. The Advancing Care Information performance category replaces the Medicare EHR Incentive Program for eligible professionals, also known as Meaningful Use, and provides greater flexibility in choosing measures. This category is worth 25% of the MIPS eligible clinician's final score.

In 2017, there are 2 measure set options for submission depending on the Certified EHR Technology (CEHRT) edition a clinician is using:

- Advancing Care Information Objectives and Measures
- 2017 Advancing Care Information Transition Objectives and Measures

Depending on the CEHRT Edition, there will be different objectives from which the MIPS eligible clinician may choose to report.

MIPS eligible clinicians using EHR technology certified to the 2015 Edition have two options from which they may choose to report:

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

MIPS eligible clinicians using EHR technology certified to the 2014 Edition have two options from which they may choose to report:

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

continued

Performance Category
Advancing Care Information

Reporting Requirements for 2017

The Advancing Care Information performance category is comprised of a base score and a performance score. Submitting all required measures in the base score is necessary to earn any credit in the advancing care information performance category.

Test:

- Submit all of the base score measures (either 4 or 5 depending on the CEHRT Edition) to avoid a negative payment adjustment.

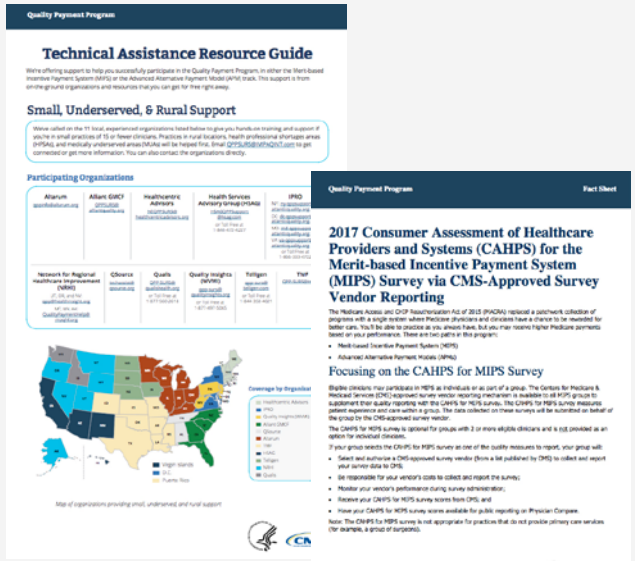
Partial or Full:

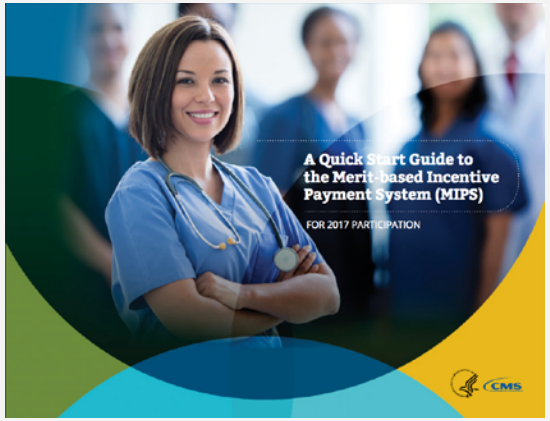
- Submit the base score measures for a minimum of 90 consecutive days.
- Submit selected performance and/or bonus measures to receive a positive payment adjustment.

For 2017, please note that the MIPS payment adjustment is determined by performance across the Quality, Improvement Activities, and Advancing Care Information performance categories.

When choosing to submit data using a combination of EHR technologies certified to the 2014 and 2015 editions, you may not submit a measure from the ACI measure set that correlates to a 2017 ACI transition measure. For example, if you submit the Provide Patient Access 2017 ACI transition measure (worth up to 20%), you may not also submit the correlating ACI measures Provide Patient Access (worth up to 10%) and/or Patient-Generated Health Data (worth up to 10%). For additional information, see the Advancing Care Information fact sheet.

RESOURCE LIBRARY





Resource Library

- **QPP Overview Fact Sheet:** This fact sheet is designed to provide an overview of QPP, eligibility, scoring categories, and additional requirements.
- **Advancing Care Information Performance Category Fact Sheet:** This fact sheet is a guide to understanding the advancing care information performance category scoring methodology as well as the different types of measures.
- **Transforming Clinical Practice Initiative (TCPI):** TCPI is designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies. Clinicians participating in TCPI will have the advantage of learning about MIPS and how to move toward participating in Advanced APMs. Click here to find help in your area.
- **Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs):** The QIO Program's 14 QIN-QIOs bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. More information about QIN-QIOs can be found here.
- **If you're in an APM:** The Innovation Center's Learning Systems can help you find specialized information about what you need to do to be successful in the Advanced APM track. If you're in an APM that is not an Advanced APM, then the learning Systems can help you understand the special benefits you have through your APM that will help you be successful in MIPS. More information about the Learning Systems is available through your model's support inbox.
- **MIPS APMs Fact Sheet:** A resource for eligible clinicians practicing in MIPS APMs. This resource explains the alternate requirements and special scoring standards.

Glossary of Terms

APM	CEHRT	CMS	EHR	MIPS	NPI	QCDR	QPP	TIN
Alternative Payment Model	Certified Electronic Health Record Technology	Centers for Medicare & Medicaid Services	Electronic Health Record	Merit-based Incentive Payment System	National Provider Identifier	Qualified Clinical Data Registry	Quality Payment Program	Taxpayer Identification Number