

Quality Payment PROGRAM

AN INTRODUCTION TO:

Group Participation in the
Merit-based Incentive Payment
System (MIPS) in 2017



How to Use this Guide

3

Overview

4

MIPS and PQRS

13

MIPS Milestones

17

Data Submission Mechanisms

19

Data Submission & Performance Category

23

Data Submission Checklists

29

Registration

36

Post-Data Submission

38

Resources

41

Glossary of Terms

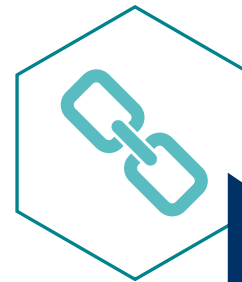
43

How to Use this Guide



Table of Contents

The table of contents is **interactive**. Click on a chapter to read that section, and then click on the chapter title to return to the table of contents.



Hyperlinks

Hyperlinks to the CMS website are included throughout the guide to direct the reader to more information and resources.



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 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.

OVERVIEW





What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) streamlined three legacy programs with the Quality Payment Program.

These legacy programs include:

Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals; Physician Quality Reporting System (PQRS); and Value-Based Payment Modifier (VM).

There are two ways to take part in the Quality Payment Program:

Merit-based Incentive Payment System

MIPS





Advanced Alternative Payment Models

APMs

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 participants receive a payment adjustment based on performance in four categories:

Highlights of Category			
Quality	Cost	Improvement Activities	Advancing Care Information
 <ul style="list-style-type: none"> Assesses the value of care to ensure patients get the right care at the right time Replaces PQRS 60% of MIPS score 	 <ul style="list-style-type: none"> Helps create efficiencies in Medicare spending Replaces Value Modifier No reporting requirement 0% of MIPS score in 2017 	 <ul style="list-style-type: none"> Supports care coordination, patient engagement, patient safety, population management, and health equity New performance category 15% of MIPS score 	 <ul style="list-style-type: none"> Supports the secure exchange of health information and the use of certified EHR technology Replaces Medicare EHR Incentive Program for Eligible Professionals, also known as meaningful use 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 clinicians include:



Physicians*



Physician Assistants



Nurse Practitioners



Clinical Nurse Specialists



Certified Registered Nurse Anesthetists

**Physicians include doctors of medicine, doctors of osteopathy (including osteopathic practitioners), doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. (With respect to certain specialized treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.)*

Any clinician group that includes one of the professionals listed above

Who is exempt from participating in MIPS?

Clinician types who are not included in the definition of a MIPS eligible clinician are exempt from participating in MIPS. Also, clinicians may be eligible for an exclusion. If a clinician is eligible for one of three exclusions, then the clinician would be exempt from participating in MIPS.

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 clinicians and are exempt from MIPS participation. Partial QPs who do not report on measures and activities that are required to be reported under MIPS for a given performance period in a year are not considered a MIPS clinician and are exempt from MIPS participation.
3	A MIPS clinician or group that does not exceed the low-volume threshold (has Medicare Part B billing charges less than or equal to \$30,000 or provides care for 100 or fewer Part B-enrolled Medicare beneficiaries) is exempt from MIPS participation for the performance period with respect to a year.

Can non-patient facing MIPS eligible clinicians participate?

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

A group is considered non-patient facing if more than 75% of NPIs billing under the group's Taxpayer Identification Number (TIN) during a performance period are labeled as non-patient facing.

How is a group defined under MIPS?

A group is defined as a single TIN with two or more MIPS clinicians (including at least one MIPS clinician) as identified by their National Provider Identifiers (NPIs) who have reassigned their Medicare billing rights to the TIN. Groups have the option to report at the individual (NPI) or group (TIN/NPI) level. For groups that elect to report 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. The group will receive one payment adjustment for the group's performance.

How are groups assessed and scored if groups include clinicians that are exempt from MIPS participation?

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

There are three types of MIPS exclusions:

1. New Medicare-enrolled clinicians,
2. QPs and Partial QPs who do not report on applicable MIPS measures and activities, and
3. Clinicians who do not exceed the low-volume threshold, which determines when a clinician is not considered a MIPS clinician and thus, not required to participate in MIPS.

The two types of exclusions pertaining to new Medicare-enrolled clinicians, and QPs and Partial QPs who do not report 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 Exempt from 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 at the group level in relation to each exclusion circumstance. For example, groups participating at the group level that include new Medicare-enrolled clinicians, or QPs or Partial QPs, would have the MIPS payment adjustment only apply to the Medicare Part B allowable charges pertaining to the group's MIPS clinicians and the MIPS payment adjustment 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, or a QP would not receive a MIPS payment adjustment, regardless of their MIPS participation. Partial QPs would have the opportunity to decide whether they wish to be subject to a MIPS payment adjustment, which could be positive or negative.

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 that exceeds the low-volume threshold.

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

Individual clinicians who do not meet the definition of a MIPS 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 report for MIPS at the individual level will not receive a MIPS payment adjustment.



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

MIPS AND PQRS



What is the difference between group participation under PQRS and MIPS?

Group participation under MIPS includes features of the PQRS Group Practice Reporting Option (GPRO). The process for MIPS was established to reflect the range of items and services provided by MIPS eligible clinicians. Differences between group participation under MIPS and PQRS GPRO include:

MIPS		PQRS
Participation and Eligibility		
To participate in MIPS as a group, the group must exceed the established low-volume threshold.		Professionals were required to participate in PQRS if they provide services that are paid under or based on the Medicare Physician Fee Schedule.
Registration		
Registration is only required to report as a group if the group elects to report via the CMS Web Interface and 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.		The group practice needed to complete Group Reporting Option (GPRO) registration through the online Physician Value-Physician Quality Reporting System (PV-PQRS) Registration System.

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MIPS	PQRS
Submission Mechanisms	
<p>For each of the Quality, Improvement Activities, and Advancing Care Information performance categories, groups are able to choose from a list of available submission mechanisms.</p> <p>Based on the MIPS performance category, groups can choose from the following submission mechanisms:</p> <ul style="list-style-type: none"> ● Qualified Clinical Data Registry (QCDR) ● Qualified Registry ● EHR ● CMS Web Interface (only available for groups with 25 or more clinicians) ● Attestation (for Improvement Activities and Advancing Care Information performance categories) <p>Groups of any size have the option to administer the CAHPS for MIPS Survey, which must be reported in conjunction with another submission mechanism.</p>	<p>Groups of 2-24 clinicians had to choose from the following reporting mechanisms:</p> <ul style="list-style-type: none"> ● Qualified Registry ● Data Submission Vendor (DSV) ● EHR Direct ● QCDR <p>Groups of 25 or more clinicians had to choose from the following reporting mechanisms:</p> <ul style="list-style-type: none"> ● Qualified Registry ● Data Submission Vendor EHR Direct ● QCDR ● GPRO Web Interface <p>Groups were required to report using the submission mechanism selected during registration. CMS did not combine data from different reporting mechanisms when analyzing PQRS program data.</p> <p>Groups of 100 or more clinicians were required to administer the CAHPS for PQRS Survey. Groups of 2-99 had the option to administer the CAHPS for PQRS survey.</p>



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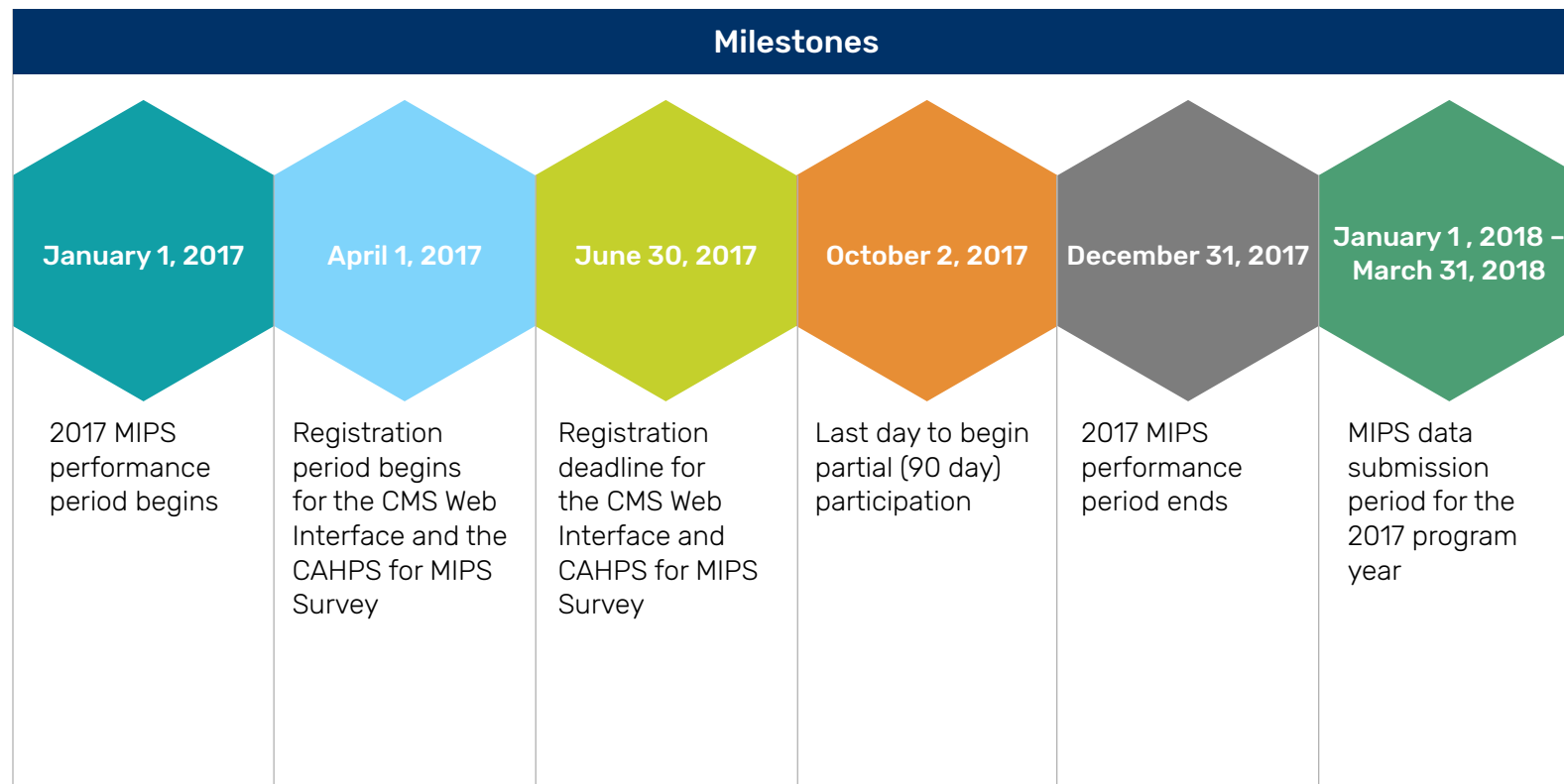
MIPS	PQRS
Scoring	
<p>A group electing to submit data at the group level would have its performance assessed and scored across the TIN, which could include items and services furnished by individual NPIs within the TIN who are not required to participate in MIPS. A MIPS clinician participating via a group will get the group's score. However, if the same MIPS clinician also submits individual level data, CMS will use the higher score for that clinician.</p>	<p>A group electing to submit data at the group level had its performance assessed and scored across the TIN.</p>
Payment Adjustments	
<p>Each clinician participating in MIPS via a group will receive a payment adjustment based on the group's performance.</p>	<p>Payment adjustments apply to items and services paid under the Medicare Physician Fee Schedule and furnished by eligible professionals under a TIN.</p>

MIPS MILESTONES



What are the important participation milestones for MIPS?

Participation and submission deadlines are included in the chart below.



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, Advancing Care Information and Cost. The Cost performance category does not have a reporting requirement in 2017.

Groups can report, or submit data, using different submission mechanisms for each performance category. Groups may use only one submission mechanism per performance category.

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	<ul style="list-style-type: none"> ● Qualified Registry – 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 clinicians. ● Electronic Health Record (EHR) – MIPS 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 groups of 25 or more MIPS clinicians reporting 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 data for the pre-populated Medicare patients. ● 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.

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Performance Category	Data Submission Mechanisms
Quality	<ul style="list-style-type: none"> ● 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 6 measures, for a total possible score of 60 points. No data submission action is required for administrative claims.
Improvement Activities	<ul style="list-style-type: none"> ● Qualified Registry ● QCDR ● EHR ● CMS Web Interface (groups with 25 or more clinicians) ● Attestation
Advancing Care Information	<ul style="list-style-type: none"> ● Qualified Registry ● QCDR ● EHR ● CMS Web Interface (groups with 25 or more clinicians) ● Attestation



APPROVED QUALIFIED REGISTRIES AND QCDRs

Groups who use qualified registries and QCDRs must choose from the list approved by CMS to ensure the entity meets CMS submission standards and criteria.

- Groups can find an [approved list of QCDRs](#) on the [CMS website](#).
- Groups can find an [approved list of qualified registries](#) on the [CMS website](#).

**DATA SUBMISSION
& PERFORMANCE
CATEGORY**





SUBMISSION MECHANISM AND PERFORMANCE CATEGORY - QUALITY

What are the measures for the Quality performance category?

Within the Quality performance category, most groups will need to select at least 6 measures to report for partial participation (90 days) and full participation (365 days).

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.

Are there different measures for each submission mechanism?

Measures change for each submission mechanism available under the Quality performance category. *Note:* Groups that choose CMS Web Interface as their data submission mechanism are expected to report on all measures included in the CMS Web Interface for a full year.

Submission Mechanism					
Administrative Claims*	Qualified Registry	QCDR	EHR	CMS Web Interface	CAHPS for MIPS Survey (labeled as CSV on QPP Measures Tool)
Quality Measures Available For 2017					
1	243	243	53	15 (all 15 must be completed under this option)	The entire survey must be completed

**Administrative Claims only applies to the population-based All-Cause Hospital Readmission measure, and no separate data submission is required outside of the normal claims process.*



SUBMISSION MECHANISM AND PERFORMANCE CATEGORY - ADVANCING CARE INFORMATION

What are the measures for Advancing Care Information?

In 2017, there are two measure sets for participation based on the certified EHR Technology (CEHRT) edition:

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

Groups need to fulfill the required base score measures for a minimum of 90 days to earn credit for the Advancing Care Information performance category. Groups may also submit performance score measures and bonus score measures.

See Appendix A in the Advancing Care Information Performance Category Fact Sheet for the full list of Advancing Care Information Measures and 2017 Advancing Care Information Transition Measures. Detailed guidance outlining each element of each Advancing Care Information Measures and 2017 Advancing Care Information Transition Measures can be found in the Advancing Care Information Measure Specification Sheets.



How does automatic reweighting of the Advancing Care Information performance category apply to groups?

MIPS clinicians who are part of a group and have assigned their billing rights to the group's TIN will be assessed as part of the group, and will not have their Advancing Care Information score reweighted to zero. Groups have the option to include or not include data from the following MIPS clinicians that qualify for an automatic reweighting:

- Hospital-based MIPS eligible clinicians
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Ambulatory Surgical Center (ASC)– based MIPS eligible clinicians

Groups will be automatically reweighted if all of their clinicians (clinician types noted above) qualify. If any clinician within the group does not qualify for a reweighting, the group must submit data to CMS.

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 reweighting.



How does the Advancing Care Information performance category apply to groups with clinicians facing a significant hardship?

If all of the MIPS clinicians in a group face a significant hardship that would qualify for reweighting, the group may [submit an application](#) to have their Advancing Care Information performance category score be reweighted to zero. If approved, the group will have their Advancing Care Information performance category score reweighted to zero and the category weight will be reallocated to quality. If any clinician within the group does not qualify for a significant hardship, the clinician(s) that qualify may apply individually. Groups with clinicians that qualify and are approved for hardship exceptions individually, do not need to submit data for those clinicians. Note: All MIPS eligible clinicians must qualify for reweighting (either automatic or through an approved hardship application) for the group to be reweighted.

Are there different measures for each submission mechanism?

Measures do not change for each submission mechanism available under the Advancing Care Information performance category.



SUBMISSION MECHANISM AND PERFORMANCE CATEGORY - IMPROVEMENT ACTIVITIES

What are the measures for Improvement Activities?

Within the Improvement Activities performance category, most groups must submit between 2 and up to 4 improvement activities for a minimum of 90 days.

Groups with 15 or fewer clinicians or clinicians in a rural or health professional shortage area submit up to 2 activities for a minimum of 90 days.

Are there different measures for each submission mechanism?

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

DATA SUBMISSION CHECKLISTS





QCDR SUBMISSION MECHANISM CHECKLIST

Use the checklist below for group data submission via QCDR, which can be used for the Quality, Improvement Activities, and Advancing Care Information performance categories.

Group Role	Vendor Role
<ul style="list-style-type: none"> ✓ Choose a CMS-approved QCDR. ✓ Determine how you will participate (e.g., test, partial year, or full year). ✓ Choose measures and/or activities. ✓ Report data for the 2017 calendar based on your participation level. ✓ Work directly with a QCDR to submit 2017 data by March 31, 2018. 	<ul style="list-style-type: none"> ✓ Ensure the QCDR has an Enterprise Identity Management account. ✓ Use Medicare claims to verify TIN combination; ensure group's TIN combination is correct on file submission. ✓ Obtain consent of clinicians in group before submission. ✓ Data must be submitted in the QRDA III format (using IG for 2017) or the QPP data format (XML or JSON). Registry and QCDR XML formats are no longer supported.





QUALIFIED REGISTRY SUBMISSION MECHANISM CHECKLIST

Use the checklist below for group data submission via qualified registry, which can be used for the Quality, Improvement Activities, and Advancing Care Information performance categories.

Group Role	Vendor Role
<ul style="list-style-type: none"> ✓ Choose a CMS qualified registry. ✓ Determine how you will participate (e.g., test, partial year, or full year). ✓ Choose measures and/or activities. ✓ Report data for the 2017 calendar based on your participation level. ✓ Work directly with a registry to submit 2017 data by March 31, 2018. 	<ul style="list-style-type: none"> ✓ Ensure the qualified registry has an Enterprise Identity Management account. ✓ Use Medicare claims to verify TIN combination; ensure group's TIN combination is correct on file submission. ✓ Obtain consent of clinicians in group before submission. ✓ Data must be submitted in the QPP data format (XML or JSON). Registry and QCDR XML formats are no longer supported.



ELECTRONIC HEALTH RECORD SUBMISSION MECHANISM CHECKLIST

Use the checklist below for group data submission via electronic health record (EHR), which can be used for the Quality, Improvement Activities, and Advancing Care Information performance categories.

Group Role	Vendor Role
<ul style="list-style-type: none"> ✓ Determine how you will participate (e.g., test, partial year, or full year). ✓ Choose measures and/or activities. ✓ Report data for the 2017 calendar based on your participation level. ✓ Work directly with a certified EHR to submit 2017 data by March 31, 2018. 	<ul style="list-style-type: none"> ✓ Use Medicare claims to verify TIN combination; ensure group's TIN combination is correct on file submission. ✓ Obtain consent of clinicians in group before submission. ✓ Submit measure data: <ul style="list-style-type: none"> ● 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 SUBMISSION MECHANISM CHECKLIST

Use the checklist below for group data submission via attestation, which can be used only for the Improvement Activities and Advancing Care Information performance categories.

Group Role	Vendor Role
<ul style="list-style-type: none"> ✓ Determine how you will participate (e.g., test, partial year, or full year). ✓ Choose measures and/or activities for one or each category depending on your group's MIPS performance period. ✓ Report data for the 2017 calendar based on your participation level. 	<ul style="list-style-type: none"> ✓ Use Medicare claims to verify TIN combination; ensure group's TIN combination is correct on file submission. ✓ Obtain consent of clinicians in group before submission. ✓ Complete attestation by March 31, 2018.





CMS WEB INTERFACE SUBMISSION MECHANISM CHECKLIST

Use the checklist below to submit the group's data via the CMS Web Interface, which can be used for Quality, Improvement Activities, and Advancing Care Information performance categories.

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.

- ✓ Register between April 1 and June 30, 2017 with the [CMS Enterprise Portal](#).
- ✓ Ensure the group has an [Enterprise Identity Management account](#).
- ✓ Use Medicare claims to verify TIN combination; ensure group's TIN combination is correct on file submission.
- ✓ Obtain consent of clinicians in group before submission.
- ✓ The submission period for the CMS Web Interface is from January 22 through March 16, 2018.
- ✓ Data can either be manually entered or uploaded into the CMS Web Interface via an Excel file, which can be populated by a certified EHR.



CAHPS FOR MIPS SURVEY CHECKLIST

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

- ✓ Register between April 1 and June 30, 2017 via the [CMS Enterprise Portal](#).
- ✓ Select and authorize a **CMS-approved survey vendor** (from a list published by CMS) to collect and report your survey data to CMS.
- ✓ Be responsible for your vendor costs to collect and report the survey.
- ✓ Monitor your vendor's performance during survey administration.
- ✓ Receive your CAHPS for MIPS Survey scores from CMS.
- ✓ Have your CAHPS for MIPS Survey scores available for public reporting on Physician Compare.

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 with the [CMS Enterprise Portal](#) if they elect to report data via the CMS Web Interface and/or administer the CAHPS for MIPS Survey. The registration period is from April 1 to June 30, 2017.

If your group registered for the GPRO Web Interface in 2016 to report for PQRS, CMS automatically registered your group to use the CMS Web Interface in 2017 for MIPS. If under PQRS you elected the CAHPS for PQRS survey, you were not automatically registered to administer the CAHPS for MIPS Survey and will need to log in to the registration system to make that election, again, if you would like to continue.

CMS does not require registration for groups submitting data via Qualified Registry, QCDR, or EHR. Also, groups that participate in a Shared Savings Program ACO are not required to register; the Shared Savings Program ACO is required to report quality measures on behalf of participating MIPS clinicians for purposes of MIPS.

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.

Also, groups that registered for the GPRO Web Interface in 2016 to report for PQRS, should cancel their registration during this timeframe if they plan to submit data through another submission mechanism for MIPS.

POST-DATA SUBMISSION



How is the group's data scored?

Groups 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 three MIPS performance categories for the 2017 program year.

How are payment adjustments applied?

Each clinician participating in MIPS via a group 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 highest final score between those two scores and apply the MIPS payment adjustment.

If a clinician billed Medicare Part B charges under more than one group (TIN) during the performance period, such clinician is required to participate in MIPS for each TIN association unless the clinician (NPI) is excluded from MIPS for a particular TIN(s) based on one of the three exclusions (see page 8 for exclusions). For clinicians associated with multiple TINs, the clinician will either report at the individual level if the group elects to report at the individual level or be included in the group-level reporting if the group elects to report at the group level. Such clinicians will be assessed and scored for each associated TIN/NPI combination and receive a MIPS payment adjustment for each associated TIN/NPI combination.

In the case where a MIPS eligible clinician starts working in a new practice or otherwise establishes a new TIN that did not exist during the performance period, there would be no corresponding historical performance information or final score for the new TIN/NPI. If there is not a final score associated with a TIN/NPI from the performance period, CMS will use the NPI's performance for the TIN(s) the NPI was billing under during the performance period.

If a clinician worked in one practice (TIN A) in the performance period, but is working at a new practice (TIN B) during the payment year, then CMS will use the final score for the old practice (TIN A/NPI) to apply the MIPS payment adjustment for the NPI in the new practice (TIN B/NPI).

If a clinician billed under more than one TIN during the performance period, and the clinician starts working in a new practice or otherwise establishes a new TIN that did not exist during the performance period, CMS will take the highest final score associated with the NPI in the performance year.

Any individual (NPI) included in the TIN who is excluded from MIPS because they are identified as a new Medicare-enrolled clinician, a QP or Partial QP, or does not exceed the low-volume threshold would not receive a MIPS payment adjustment, regardless of their MIPS participation.

CMS will only apply the MIPS payment adjustments to Medicare Part B allowed charges.

RESOURCES





The screenshot displays three key CMS resources. At the top left is the 'Technical Assistance Resource Guide' for the Quality Payment Program, which offers support for participating in MIPS. Below it is a 'Small, Underserved, & Rural Support' section. To the right is a 'Fact Sheet' titled '2017 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for the Merit-based Incentive Payment System (MIPS) Survey via CMS-Approved Survey Vendor Reporting'. This fact sheet includes a table of participating organizations (Altogether, Alliant GPC, Healthcare Delivery, Health Services, IPAD) and a map of the United States showing regions for MIPS participation. At the bottom is a 'Quick Start Guide to the Merit-based Incentive Payment System (MIPS) FOR 2017 PARTICIPATION' featuring a photo of a healthcare professional.

Additional Resources

- A Quick Start Guide for the Merit-based Incentive Payment System
- MIPS Participation Fact Sheet
- MIPS Improvement Activities Fact Sheet
- Advancing Care Information Fact Sheet
- Advancing Care Information Measure Specifications
- Advancing Care Information Measure Specification Fact Sheet
- CMS Web Interface Fact Sheet
- CAHPS for MIPS Fact Sheet
- Technical Assistance Resource Guide
- List of 2017 QCDRs
- List of 2017 Qualified Registries

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