Quality Payment
PROGRAM

PARTICIPATION CRITERIA FOR YEAR 2 OF THE QUALITY PAYMENT PROGRAM (2018)

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Topics

- Merit-based Incentive Payment System (MIPS)
- MIPS Year 2 (2018)
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  - Participating as an Individual
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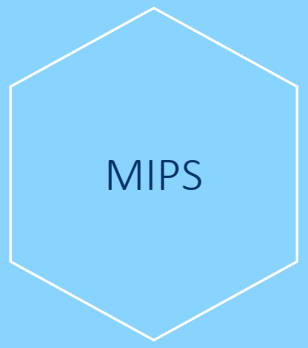
Quality Payment Program

MIPS and Advanced APMs

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, that provides for two participation tracks:



The Merit-based Incentive Payment System (MIPS)

If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

OR

Advanced Alternative Payment Models (Advanced APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.

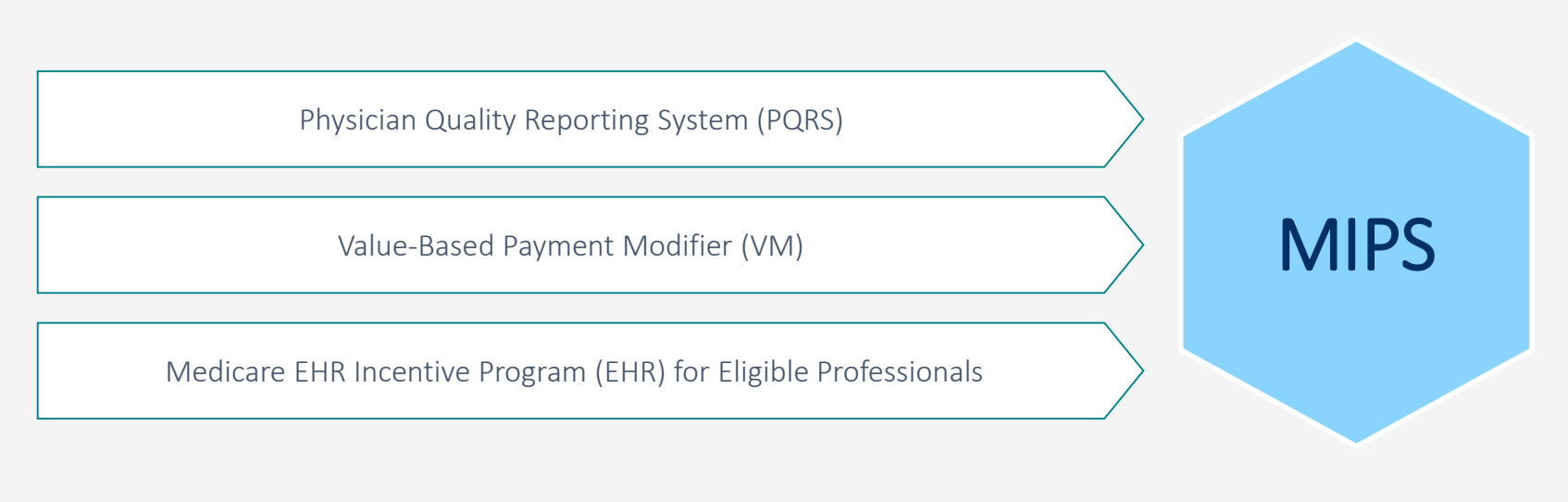
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Basics for Year 2 (2018)

Merit-based Incentive Payment System (MIPS)

Quick Overview

Combined legacy programs into a single, improved program.



Merit-based Incentive Payment System (MIPS)

Quick Overview

MIPS Performance Categories for Year 2 (2018)

- Comprised of **four** performance categories in 2018.
- So what? *The points from each performance category are added together to give you a MIPS Final Score.*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

Merit-based Incentive Payment System (MIPS)

Changing Advancing Care Information to Promoting Interoperability

- On April 24, 2018, CMS released the Medicare Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) proposed rule.

- This rule established a new name for the MIPS Advancing Care Information performance category – the **Promoting Interoperability** performance category.

- This new name better reflects CMS' new focus on improving program flexibility, reducing provider burden, and promoting interoperability and the sharing of health care data between providers.

- To learn more, view the proposed rule, press release, and fact sheet on the proposed rule.

MIPS YEAR 2 (2018)

Participation Basics

MIPS Year 2 (2018)

Participation Basics

In Year 2 (2018) of the Quality Payment Program, eligible clinicians can participate in MIPS:

- As an individual;
- As a group;
- As a virtual group; or
- In an APM

MIPS YEAR 2 (2018)

Participating as an Individual

MIPS Year 2 (2018)

Who is Included?

No change in the types of clinicians eligible to participate in 2018.

MIPS eligible clinicians include:

Physicians

Physician Assistants

Nurse Practitioners

Clinical Nurse Specialists

Certified Registered Nurse Anesthetists

MIPS Year 2 (2018)

Who is Included?

Change to the Low-Volume Threshold for 2018. Includes MIPS eligible clinicians billing more than $90,000 a year in allowed charges for covered professional services under the Medicare PFS **AND** furnishing covered professional services to more than 200 Medicare beneficiaries a year.

Voluntary reporting remains an option for those clinicians who are exempt from MIPS.

MIPS Year 2 (2018)

Determining Participation in Year 2

No change to eligibility determination process.

1. CMS verifies that you meet the definition of a MIPS eligible clinician type.

Then…

2. CMS reviews your historical PFS claims data from **9/1/16 to 8/31/17** to make the initial determination.
   - "So what?" –
     - If you are determined to be exempt during this review, you will remain exempt for the entirety of Year 2 (2018).

Later…

3. CMS conducts a second determination on performance period PFS claims data from **9/1/17 to 8/31/18**.
   - "So what?" -
     - If you were included in the first determination, you may be reclassified as exempt for Year 2 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.

MIPS Year 2 (2018)

Participating in Multiple Practices

You Have Asked: *"What if I am associated with multiple practices?"*

- A MIPS eligible clinician who is in multiple practices is required to participate in MIPS for ***each associated practice*** (TIN/NPI) where he or she exceeds the low volume threshold.
- MIPS eligible clinicians will receive a payment adjustment based on the TIN/NPIs where the low volume threshold was exceeded.
- Any associated practices (TIN/NPIs) where the MIPS eligible clinician did not exceed the low volume threshold (or was otherwise excluded from MIPS) would not receive a payment adjustment.

MIPS Year 2 (2018)

If You're Included…

Note the ***changes*** to the performance threshold and payment adjustments.

Transition Year 1 (2017) Final

Final Score 2017	Payment Adjustment 2019
≥70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%
4-69 points	• Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not participate

Year 2 (2018) Final

Final Score 2018	Change Y/N	Payment Adjustment 2020
≥70 points	N	• Positive adjustment greater than 0% • Eligible for exceptional performance bonus—minimum of additional 0.5%
15.01-69.99 points	Y	• Positive adjustment greater than 0% • Not eligible for exceptional performance bonus
15 points	Y	• Neutral payment adjustment
3.76-14.99	Y	• Negative payment adjustment greater than -5% and less than 0%
0-3.75 points	Y	• Negative payment adjustment of -5%

MIPS Year 2 (2018)

Who is Exempt?

No change in basic exemption criteria.*

Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

Below the low-volume threshold

- Allowed charges for covered professional services under the Medicare PFS less than or equal to $90,000 a year

OR

- Furnish services to 200 or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs

- Receive 25% of their Medicare payments

OR

- See 20% of their Medicare patients through an Advanced APM

**Only Change to Low-volume Threshold*

MIPS YEAR 2 (2018)

Participating as a Group

MIPS Year 2 (2018)

Participating at the Group Level

You Have Asked: *"Does the $90,000 in allowed charges for covered professional services under the PFS **AND** 200 Medicare Part B beneficiaries who are furnished covered professional services under the PFS also apply at the group level if my practice chooses group reporting?"*

Yes. For Year 2 (2018), the Low-Volume Threshold for MIPS also applies at the group level.

"So what?" – The low-volume threshold exclusion is based on both the individual (TIN/NPI) and group (TIN) status. For group-level reporting, a group (as a whole) is assessed to determine if it exceeds the low-volume threshold.

MIPS Year 2 (2018)

Participating at the Group Level

Example

Individually
(Assessed at the TIN/NPI Level)

Dr. "A."

- Billed $250,000
- Saw 210 Patients

Included in MIPS

Dr. "B."

- Billed $100,000
- Saw 80 Patients

Exempt from MIPS

Nurse Practitioner

- Billed $50,000
- Saw 40 Patients

Exempt from MIPS

Group
(Assessed at the TIN Level)

As a Group
(Dr. A., Dr. B., NP)

- Billed $400,000
- Saw 330 Patients

ALL Included in MIPS

Remember: To participate BILLING >$90,000 **AND** >200

MIPS YEAR 2 (2018)

Participating as a Virtual Group

MIPS Year 2 (2018)

Virtual Groups

New: Virtual Groups

What is a virtual group?

- A virtual group can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period for a year.

- To be eligible to join or form a virtual group, you would need to be a:
  - **Solo practitioner** who exceeds the low-volume threshold individually, and is not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS.
  - **Group** that has 10 or fewer eligible clinicians and exceeds the low-volume threshold at the group level.

MIPS Year 2 (2018)

Virtual Groups

New: Virtual Groups

What else do I need to know?

- Generally, policies that apply to groups would apply to virtual groups.
- Virtual groups use same submission mechanisms as groups.
- **All** clinicians within a TIN are part of the virtual group.
- Virtual groups are required to aggregate their data across the virtual group for each performance category and will be assessed and scored as a virtual group.
- Solo practitioners and groups who want to form a virtual group must go through the **election process**.
- Virtual groups election must occur ***prior*** to the **beginning of the performance period** and cannot be changed once the performance period starts.

MIPS YEAR 2 (2018)

Special Status

MIPS Year 2 (2018)

Special Status Refresher

In Year 2 (2018) of the Quality Payment Program the following are considered special status:

- Non-Patient Facing
- Small Practice
- Rural
- Health Professional Shortage Area (HPSA)
- Hospital-Based
- Ambulatory Surgical Center-based

"So what?" – MIPS eligible clinicians with a special status are included in MIPS and qualify for special rules. Having a special status does not exempt a clinician from MIPS.

Examples of Special Rules:

- Small, Rural, HPSAs receive double points under the Improvement Activities performance category.

- Non-patient facing, Hospital-based, Ambulatory Surgical Center-based, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists all receive an automatic reweighting of the Promoting Interoperability performance category.

MIPS Year 2 (2018)

Non-patient Facing

No change in Non-Patient Facing criteria.

Transition Year 1 (2017) Final

- Individual – If you have ≤100 patient facing encounters.
- Groups – If your group has >75% of NPIs billing under your group's TIN during a performance period are labeled as non-patient facing.

Year 2 (2018) Final

- **No Change to Individual and Group policy.**
- **NEW - Virtual groups** are included in the definition.
  - Virtual groups that have >75% of NPIs within a virtual group during a performance period are labeled as non-patient facing

MIPS Year 2 (2018)

Hospital-based

- Clinicians are considered hospital-based if they provide 75% or more of their services in an:
  - Inpatient Hospital (Place of Service code 21);
  - On-campus Outpatient Hospital (POS 22);
  - Emergency Room (POS 23); or
  - Off-campus Outpatient Hospital (POS 19). (***Newly added for Year 2.***)

- Hospital-based clinicians qualify for an automatic reweighting of the Promoting Interoperability performance category to zero.
  - *However*, they can still choose to report if they would like, and, if data is submitted, CMS will score their performance and weight their Promoting Interoperability performance category accordingly.

- Hospital-based clinicians are subject to MIPS if they exceed the low-volume threshold and should report the Quality and Improvement Activities performance categories.

MIPS Year 2 (2018)

Ambulatory Surgical Center-based (ASC)

Change to add Ambulatory Surgical Center-based special status to the 2018 performance year.

- Clinicians are considered Ambulatory Surgical Center(ASC)-based if they provide 75% or more of their services in a POS code 24.
  - POS 24 defines an ASC as a freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

- ASC-based clinicians qualify for an automatic reweighting of the Promoting Interoperability performance category to zero.
  - *However*, they can still choose to report if they would like, and, if data is submitted, CMS will score their performance and weight their Promoting Interoperability performance accordingly.

- ASC-based clinicians are subject to MIPS if they exceed the low-volume threshold and should report the Quality and Improvement Activities performance categories.

- Please note that ASC-based determinations will be made independent of hospital-based determinations.

MIPS Year 2 (2018)

Small, Rural, Health Professional Shortage Areas

No change to the basic application of Small, Rural, and HPSA special status; minor changes to technical aspects.

Special Status	Component	Year 2 (2018) Final	Application
Small Practice	Definition	• Practices consisting of 15 or fewer eligible clinicians.	• **No change** to the application of these special status designations from Year 1 to Year 2.
Rural and Health Professional Shortage Areas	Rural and HPSA practice designations	• An individual MIPS eligible clinician, a group, or a virtual group with multiple practices under its TIN (or TINs within a virtual group) with **more than 75 percent** of NPIs billing under the individual MIPS eligible clinician or group's TIN or within a virtual group in a ZIP code designated as a rural area or HPSA.	

MIPS YEAR 2 (2018)

Special Rules and Considerations

MIPS Year 2 (2018)

Rural Health Clinics and Federally Qualified Health Centers

No Change to policy relating to Rural Health Clinics and Federally Qualified Health Centers.

Component	Transition Year 1 (2017) Final	Year 2 (2018) Final
Application of MIPS Payment Adjustment	• Items and services furnished by a MIPS eligible clinician and paid under the RHC or FQHC methodology, will **not** be subject to the MIPS payment adjustments. • Eligible clinicians still have the option to voluntarily report, but will not receive a MIPS payment adjustment.	• **No change** to RHC or FQHC MIPS payment adjustment policies.

MIPS Year 2 (2018)

Critical Access Hospitals

No Change to policy relating to Critical Access Hospitals.

Component	Transition Year 1 (2017) Final	Year 2 (2018) Final
Application of MIPS Payment Adjustment	• Method I – MIPS payment adjustment apply to payments made for items and services billed by MIPS eligible clinicians, but it does not apply to the facility payment to the CAH itself. • Method II (did not assign billing rights) – Same policy as Method I. • Method II (assigned billing rights) - MIPS payment adjustment will apply to Method II CAH payments when MIPS eligible clinicians who practice in Method II CAHs have assigned their billing rights to the CAH.	• No change to CAH MIPS payment adjustment policies.

MIPS Year 2 (2018)

Employment Contracts and NPI Type

No Change to the policy on employment contracts with a hospital or healthcare system.

- MIPS applies to you if the covered professional services that you furnish under the PFS are billed on your behalf by another entity, such as a hospital or health system, and the TIN meets the low volume threshold criteria.

No Change to the policy on NPI type.

- Only MIPS eligible clinicians with a Type 1 NPI need to participate in MIPS during Year 2.
- Type 2 NPIs, such as a hospital, home health agency, lab, or DME supplier, would not participate.

However…

- If you have both a Type 1 and 2 NPI AND exceed the low volume threshold, you will need to participate in MIPS.

ALTERNATIVE PAYMENT MODELS (APMS) AND ADVANCED APMS

Alternative Payment Models (APMs)

Refresher on Key Participation Terms

- APM Entity - An entity that participates in an APM or payment arrangement with a non-Medicare payer through a direct agreement or through Federal or State law or regulation.
- Advanced APM – A payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.
- Affiliated Practitioner - An eligible clinician identified by a unique APM participant identifier on a CMS-maintained list who has a contractual relationship with the Advanced APM Entity for the purposes of supporting the Advanced APM Entity's quality or cost goals under the Advanced APM.
- Affiliated Practitioner List - The list of Affiliated Practitioners of an APM Entity that is compiled from a CMS-maintained list.
- MIPS APM – Most Advanced APMs are also MIPS APMs so that if an eligible clinician participating in the Advanced APM does not meet the threshold for sufficient payments or patients through an Advanced APM in order to become a Qualifying APM Participant (QP), thereby being excluded from MIPS, the MIPS eligible clinician will be scored under MIPS according to the APM scoring standard. The APM scoring standard is designed to account for activities already required by the APM.
- Participation List - The list of participants in an APM Entity that is compiled from a CMS-maintained list.
- Qualifying APM Participant (QP) - An eligible clinician determined by CMS to have met or exceeded the relevant QP payment amount or QP patient count threshold for a year based on participation in an Advanced APM Entity.

Alternative Payment Models (APMs)

Quick Overview

APMs are approaches to paying for health care that incentivize quality and value.

The CMS Innovation Center develops new payment and service delivery models. Additionally, Congress has defined—both through the Affordable Care Act and other legislation—a number of demonstrations that CMS conducts.

As defined by MACRA, **APMs include:**

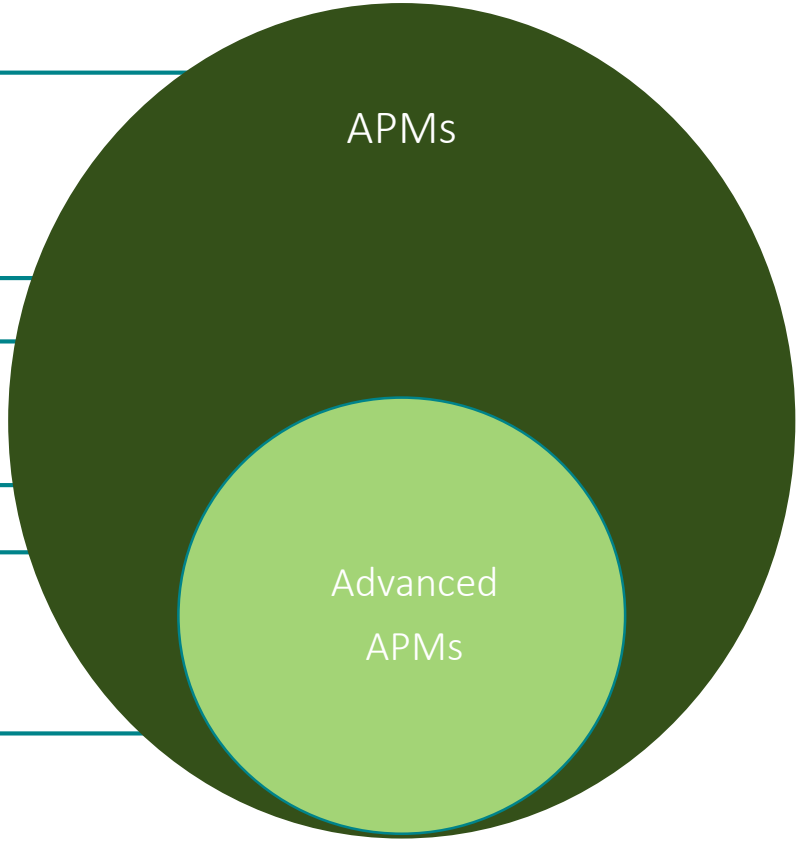
- ✓ CMS Innovation Center model (under section 1115A, other than a Health Care Innovation Award)
- ✓ Medicare Shared Savings Program
- ✓ Demonstration under the Health Care Quality Demonstration Program
- ✓ Demonstration required by federal law

Advanced Alternative Payment Models (APMs)

Quick Overview

Advanced APMs are a subset of APMs

- ✓ A payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care.
- ✓ Can apply to a specific condition, care episode or population.
- ✓ May offer significant opportunities for eligible clinicians who are not ready to participate in Advanced APMs.



Advanced APMs

Advanced APM Criteria

To be an Advanced APM, a model must meet the following three statutory requirements:

1. Requires participants to use **certified EHR technology** or holds ACO participants accountable for **certified EHR technology** use

2. Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and

3. **Either**: (1) is a **Medical Home Model expanded** under CMS Innovation Center authority OR (2) requires **participants to bear a more than nominal amount of financial risk.**

Advanced APMs

Medical Home Model

A Medical Home Model is an APM that has the following features:

Participants include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services.

Empanelment of each patient to a primary clinician; and

At least four of the following additional elements:

- ☐ Planned coordination of chronic and preventive care.
- ☐ Patient access and continuity of care.
- ☐ Risk-stratified care management.
- ☐ Coordination of care across the medical neighborhood.
- ☐ Patient and caregiver engagement.
- ☐ Shared decision-making.
- ☐ Payment arrangements in addition to, or substituting for, fee-for-service payments.

Medical Home Models are subject to different (more flexible) standards in order to meet the financial risk criterion to become an Advanced APM.

Advanced APMs

Advanced APMs in Year 2 (2018)

- Bundled Payments for Care Improvement (BPCI) Advanced*
- Comprehensive ESRD Care (CEC) – Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Medicare Accountable Care Organization (ACO) Track 1+ Model
- Next Generation ACO Model
- Shared Savings Program – Track 2
- Shared Savings Program – Track 3
- Oncology Care Model (OCM) – Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT)

*BPCI Advanced is scheduled to begin in October 2018, and participants will have an opportunity to achieve QP status, or be scored under the APM scoring standard for MIPS, starting in performance year 2019.

Advanced APMs

Qualifying APM Participant (QP)

No change to Qualifying APM Participant policy. In order to achieve status as a **Qualifying APM Participant** to **qualify for the 5% APM incentive payment for a year and be excluded from MIPS**, eligible clinicians must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through an Advanced APM during the associated performance period.

Qualifying APM Participants are eligible clinicians who have a certain **% of Part B payments for professional services or patients furnished Part B professional services** through an **Advanced APM Entity**.

Beginning in 2019, this threshold % may be reached through a combination of Medicare and other **non-Medicare payer arrangements**, such as private payers and Medicaid.

ADVANCED APMS

All-Payer Combination Option &
Other Payer Advanced APMs

All-Payer Combination Option

Overview

The MACRA statute created two pathways to allow eligible clinicians to become QPs.

Medicare Option

- Available for all performance years.
- Eligible clinicians achieve QP status exclusively based on participation in Advanced APMs within Medicare fee-for-service.

All-Payer Combination Option

- Available starting in Performance Year 2019.
- Eligible clinicians achieve QP status based on a combination of participation in Advanced APMs within Medicare fee-for-service, AND Other Payer Advanced APMs offered by other payers.

All-Payer Combination Option

Overview

- The All-Payer Combination Option is, along with the Medicare Option, one of two pathways through which eligible clinicians can become a QP for a year.
- QP Determinations under the All-Payer Combination Option will be based on an eligible clinicians' participation in a combination of both Advanced (Medicare) APMs and Other Payer Advanced APMs.
- QP Determinations are conducted sequentially so that the Medicare Option is applied before the All-Payer Combination Option.
- Only clinicians who do not meet the minimum patient count or payment amount threshold to become QPs under the Medicare Option (but still meet a lower threshold to participate in the All-Payer Combination Option) are able to request a QP determination under the All-Payer Combination Option.
- The All-Payer Combination Option is available beginning in the 2019 QP Performance Period.

All-Payer Combination Option

Other Payer Advanced APMs

Other Payer Advanced APMs are non-Medicare payment arrangements that meet criteria that are similar to Advanced APMs.

Payer types that may have payment arrangements that qualify **as Other Payer Advanced APMs** include:

- ✓ Title XIX (Medicaid)
- ✓ Medicare Health Plans (including Medicare Advantage)
- ✓ CMS Multi-Payer Models
- ✓ Other commercial and private payers

All-Payer Combination Option

Other Payer Advanced APM Criteria

The criteria for determining whether a payment arrangement qualifies as an Other Payer Advanced APM are similar, but not identical, to the comparable criteria used for Advanced APMs:

1. Requires at least 50 percent of eligible clinicians to **use certified EHR** technology to document and communicate clinical care information.

2. Base payments on **quality measures that are comparable to those used in the MIPS** quality performance category

3. Either: (1) is a Medicaid Medical Home Model that meets criteria that is **comparable to a Medical Home Model expanded** under CMS Innovation Center authority, OR (2) Requires participants to **bear more than nominal amount** of financial risk.

Advanced APMs

All-Payer Combination Option: Determination of Other Payer Advanced APMs

- Prior to each QP Performance Period, CMS will make Other Payer Advanced APM determinations based on information voluntarily submitted by payers, which we refer to as the Payer Initiated Process.

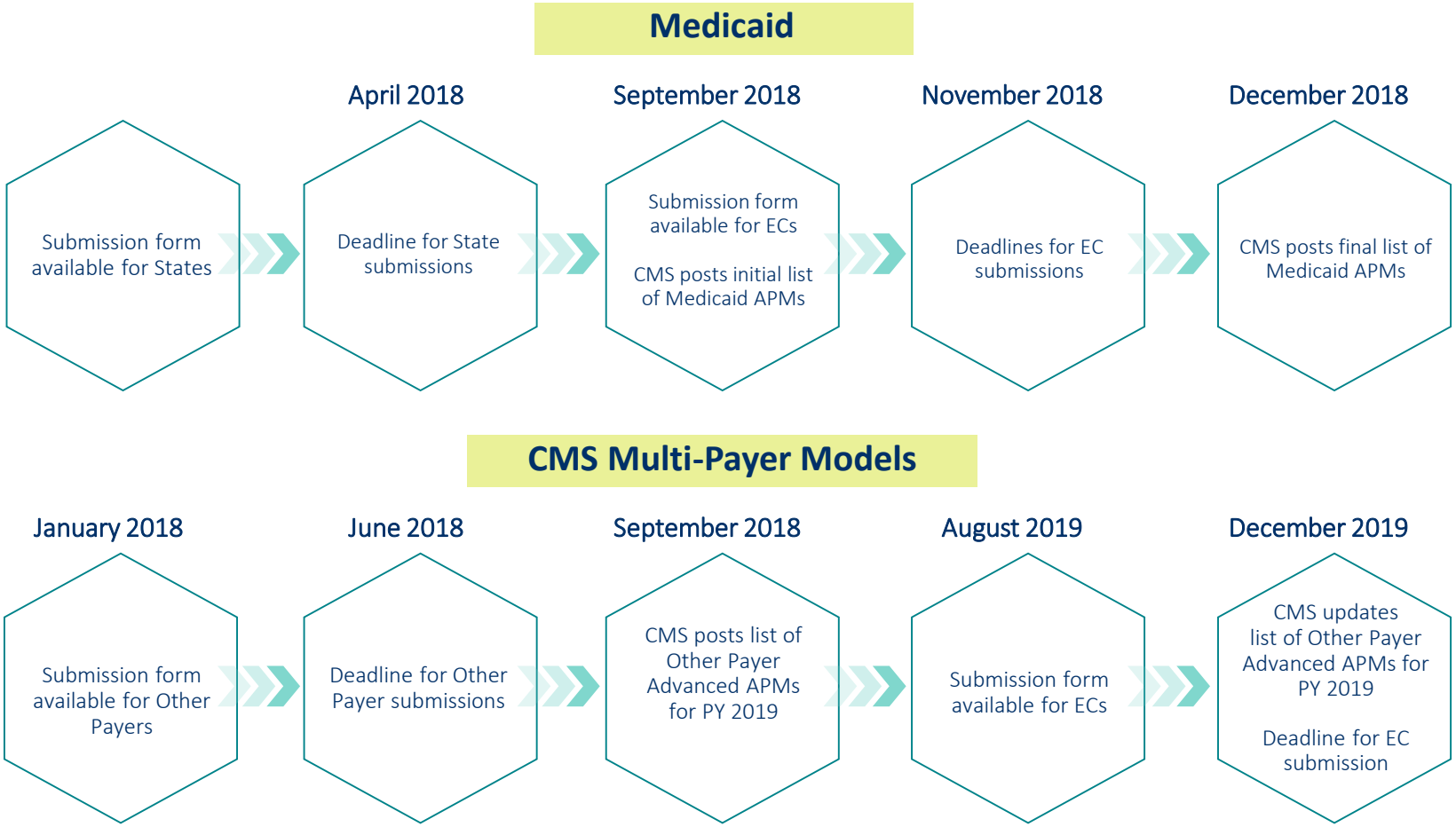
- This Payer Initiated Process is available for Medicaid, Medicare Advantage, and payers aligning with CMS Multi-Payer Models for performance year 2019. We intend to add remaining payer types in future years.

- APM Entities and eligible clinicians will also have the opportunity to submit information regarding the payment arrangements in which they were participating in the event that the payer has not already done so, which we refer to as the Eligible Clinician Initiated Process.

- For Medicaid payment arrangements, APM Entities and eligible clinicians will be able to submit information prior to the relevant QP Performance Period. For all other payment arrangements, APM Entities and eligible clinicians will be able to submit information after the relevant QP Performance Period.

Advanced APMs

All-Payer Combination Option: Performance Year 2019 Timeline for Other Payer Advanced APM Determinations



Advanced APMs

All-Payer Combination Option: Performance Year 2019 Timeline for Other Payer Advanced APM Determinations

Medicare Health Plans

June 2018
Submission form available for Medicare Health Plans

September 2018
Deadline for Medicare Health Plan submissions

August 2019
CMS posts list of Other Payer Advanced APMs for PY 2019

December 2019
Submission form available for ECs

CMS updates list of Other Payer Advanced APMs for PY 2019

Deadline for EC submissions

Remaining Other Payer Payment Arrangements

January 2018 – December 2018
Other Payer Advanced APM determinations will not be made for performance year 2019. We intend to add this option in future years.

August 2019
Submission form available for ECs

December 2019
CMS updates list of Other Payer Advanced APMs for PY 2019

Deadline for EC submissions

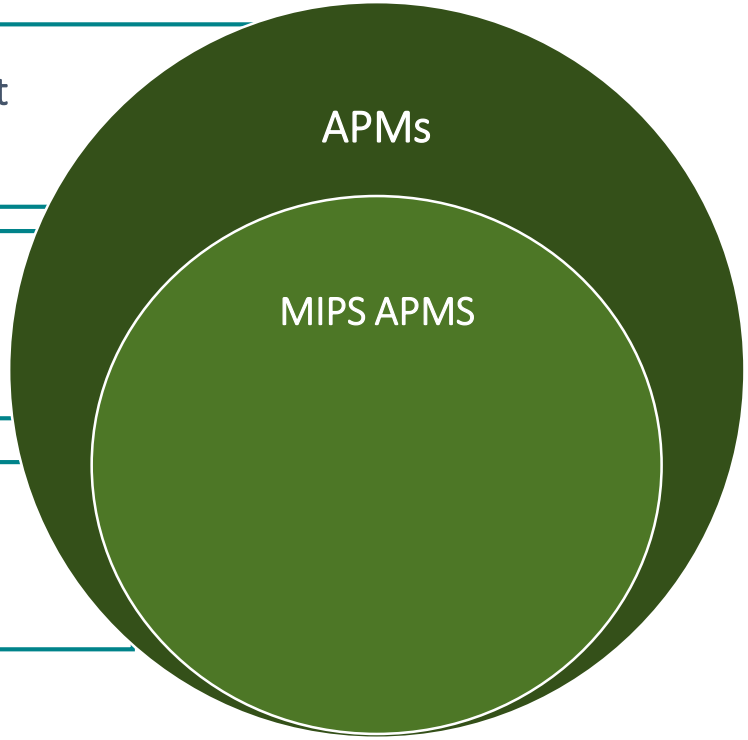
MIPS APMS

MIPS APMs

Quick Refresher

MIPS APMs are APMs that meet the following criteria:

- ✓ APM Entities participate in the APM under an **agreement with CMS**;
- ✓ APM Entities include one or more **MIPS eligible clinicians** on a Participation List; and
- ✓ APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on **cost/utilization** and **quality**.



APM Scoring Standard

Application of Low Volume Threshold

You Have Asked: *"How does the low-volume threshold apply to MIPS eligible clinicians in MIPS APMs?"*

- Applies to MIPS eligible clinicians practicing as a part of an APM Entity in a MIPS APM.
- Will be calculated by CMS at the APM Entity level.
- If you are an individual or group that is below the low-volume threshold but part of a MIPS APM (or ACO), you are subject to MIPS under the APM scoring standard.

Scenarios:

✓ The APM Entity is required to participate in MIPS if it **exceeds** the low-volume threshold.

- "So what?" - This means that groups and solo practitioners participating in the APM Entity will need to participate in MIPS for that TIN/NPI.

× The APM Entity is exempt from MIPS if it **does not exceed** the low-volume threshold.

- "So what?" - This means that groups and solo practitioners participating in the APM Entity will be exempt from MIPS for that TIN/NPI if the **entire APM Entity** does not exceed the low volume threshold.

APM Scoring Standard

Snapshot Dates

The APM scoring standard offers a special, minimally-burdensome way of participating in MIPS for eligible clinicians in APMs who do not meet the requirements to become QPs and are therefore subject to MIPS, or eligible clinicians who meet the requirements to become a Partial QP and therefore able to choose whether to participate in MIPS.

To be considered part of the APM Entity for the APM scoring standard, an eligible clinician **must be on an APM Participation List on at least one of the below three snapshot dates** of the performance period. Otherwise, an eligible clinician must report to MIPS under the standard MIPS methods.

New – FULL TIN ONLY

*Note: The **fourth snapshot date** of **December 31st is** for full TIN APMs (Medicare Shared Savings Program).

APM Scoring Standard

Category Weighting for MIPS APMs

Change: In Year 2, we are aligning the weighting across all MIPS APMs, and assess all MIPS APMs on quality.

Transition Year (2017)

Domain	SSP & Next Generation ACOs	Other MIPS APMs
	50%	0%
	0%	0%
	20%	25%
	30%	75%

Year 2 (2018) Final

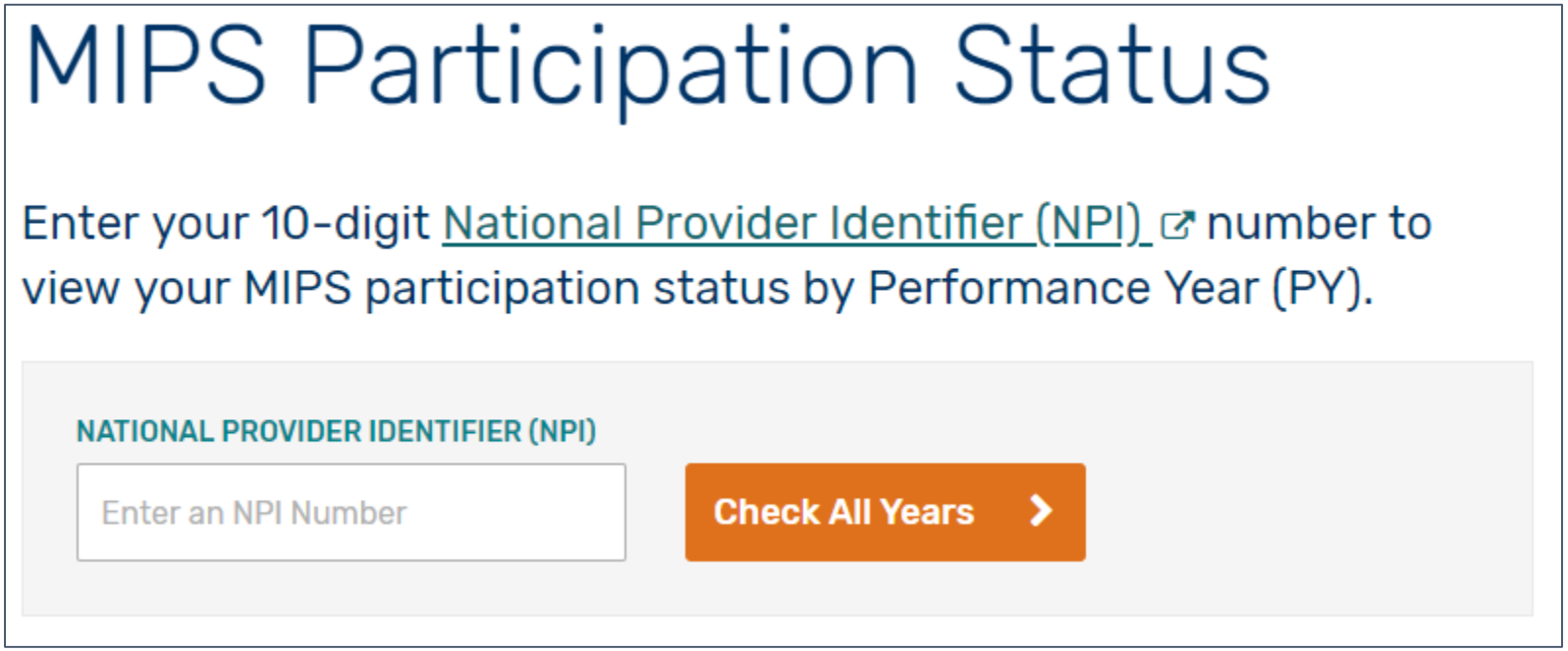
All MIPS APMs
50%
0%
20%
30%

HOW DO I CHECK MY PARTICIPATION STATUS?

Participation Status for Year 2 (2018)

Getting Started

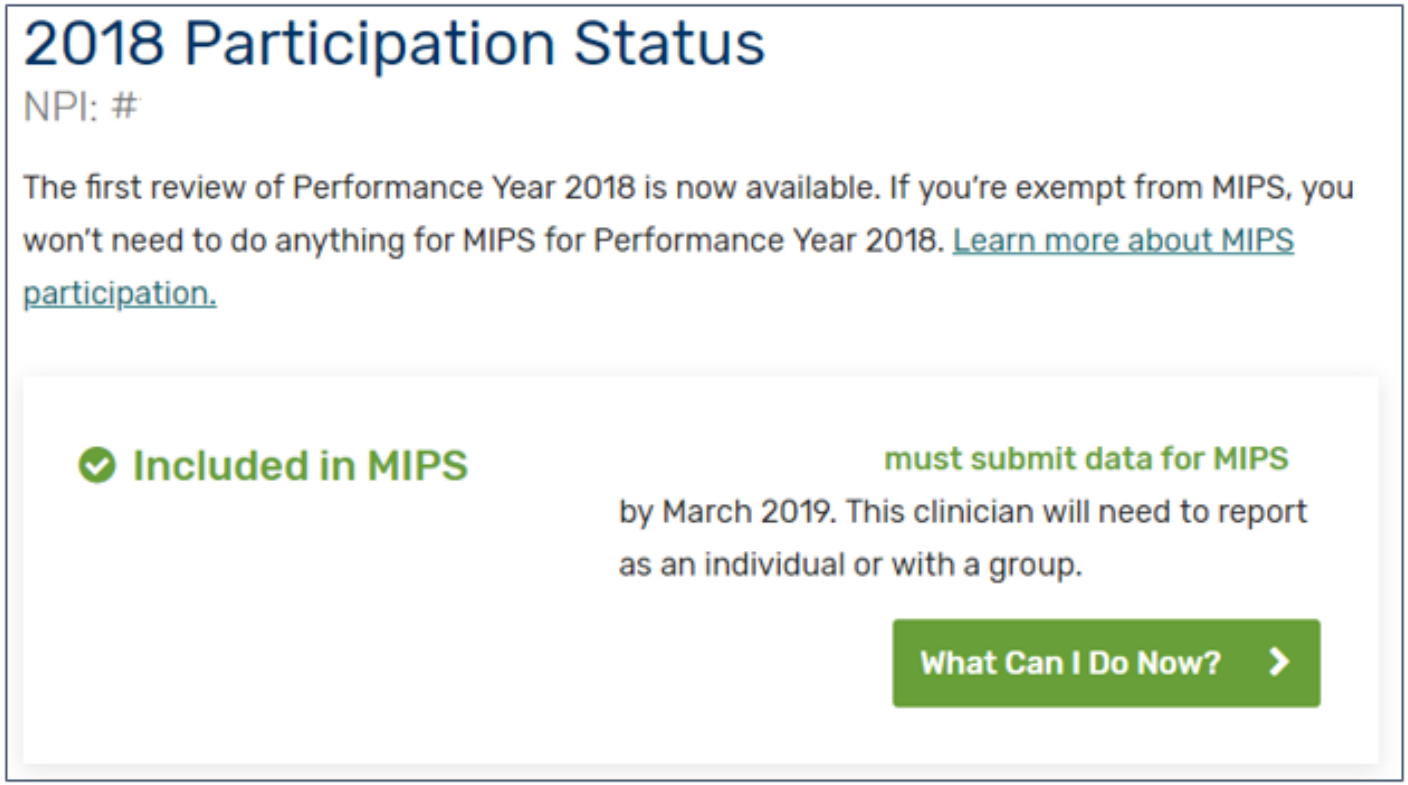
- **For MIPS:** Start by checking your participation status using the National Provider Identifier (NPI) Look-up Tool on qpp.cms.gov.
    - Please note that we did not mail individual letters outlining your Year 2 participation status.



Participation Status for Year 2 (2018)

Getting Started

- **For MIPS:** If you're included, you will see the below screen.
  - You will need to submit data for each associated TIN where you are included at the individual level.



Participation Status for Year 2 (2018)

Getting Started: Scenarios

If the clinician reports as a individual	If the clinician reports as a group *
Exempt from MIPS This clinician has billed Medicare for $90,000 or less and has provided care for 200 or fewer patients at this practice.	Exempt from MIPS This practice has billed Medicare for $90,000 or less.

You're exempt at both the individual and group level and do not need to participate.

If the clinician reports as a individual	If the clinician reports as a group *
Exempt from MIPS This clinician has billed Medicare for $90,000 or less and has provided care for 200 or fewer patients at this practice.	Included in MIPS This practice has billed Medicare for more than $90,000 and has provided care for more than 200 patients.

You're exempt at the individual level, but will need to participate *if* your TIN opts to report at the group level.

If the clinician reports as a individual	If the clinician reports as a group *
Included in MIPS This clinician has billed Medicare for more than $90,000 and has provided care for more than 200 patients at this practice.	Included in MIPS This practice has billed Medicare for more than $90,000 and has provided care for more than 200 patients.

You're included at both the individual and group level and need to participate.

Participation Status for Year 2 (2018)

Getting Started

- For APMs: You'll soon be able to use the same NPI Look-up Tool to determine your APM or Predictive Qualifying APM Participant (QP) status.

- Please note: The Look-up Tool does not yet reflect 2018 APM information. We anticipate expanding this tool to include both 2018 APM participation and predictive Qualifying APM Participant status later this spring.

- If you're interested in reviewing your 2017 APM Participant Status or MIPS APM Status, visit: https://data.cms.gov/qplookup

QUALITY PAYMENT PROGRAM

Help & Support

Technical Assistance

Available Resources

CMS has free resources and organizations on the ground to provide help to eligible clinicians included in the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISCMail@us.ibm.com for extra assistance.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
  - For more information or for assistance getting connected, contact QPPSURS@IMPAQINT.COM.

LARGE PRACTICES

Quality Innovation Networks-
Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

To learn more, view the Technical Assistance Resource Guide: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Technical-Assistance-Resource-Guide.pdf

Q&A Session

To ask a question, please dial:

1-866-452-7887

If prompted, use passcode: 5787102

Press *1 to be added to the question queue.

You may also submit questions via the chat box.

Speakers will answer as many questions as time allows.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