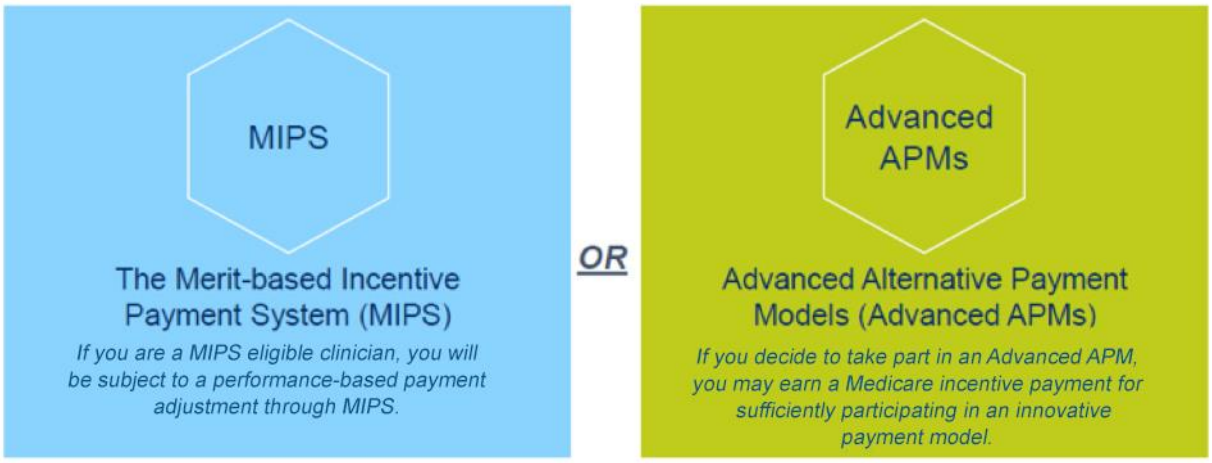
Quality Payment
PROGRAM

2018 Merit-based Incentive Payment System (MIPS) Participation & Overview

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



This fact sheet is divided into three sections:

- Quality Payment Program Year 2: MIPS participation
- Quality Payment Program Year 2: MIPS policy highlights
- Quality Payment Program: Comparing final Year 1 & Year 2 policies

Quality Payment Program Year 2: MIPS participation

Who can participate in Year 2?

For the 2018 MIPS performance year (Year 2), the following clinician types are eligible for MIPS:

- Physicians, which includes 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;
- Physician assistants (PAs);
- Nurse practitioners (NPs);
- Clinical nurse specialists;
- Certified registered nurse anesthetists; and
- Any clinician group that includes one of the professionals listed above.

How Do I Know If I'm Eligible?

The MIPS Participation Status look-up tool is a resource on qpp.cms.gov allowing clinicians and their support staff to enter a National Provider Identifier (NPI) to determine if a clinician who bills Medicare is eligible and should therefore participate in and submit data to MIPS.

The tool reflects MIPS eligibility for clinicians based on clinician type and Medicare enrollment date. It also includes their eligibility for each practice association (as identified by TIN) based on low-volume threshold calculations, as well as information about special status, such as being hospital-based.

(More information about the low-volume threshold, special status, and determination periods is provided later in this fact sheet.)

Currently, the look-up tool displays from the first determination period (historical data from September 1, 2016 through August 31, 2017.)

- If the look-up tool indicates a clinician isn't eligible for MIPS at the individual and/or group level, the eligibility status generally won't change at the practices displayed on the tool.

  Exceptions:

  - If a MIPS eligible clinician joins a new practice between September 1, 2017 and August 31, 2018, he or she may become individually eligible for MIPS based on the second low-volume threshold analysis of claims submitted under that new TIN/NPI combination.
  - Eligibility status might change for clinicians participating in an Alternative Payment Model (APM). The tool will be expanded in late Spring 2018 to include both 2018 APM participation and predictive Qualifying APM Participant (QP) status.

- If the look-up tool indicates a clinician is eligible for ("included in") MIPS at the individual and/or group level, the eligibility status may change during the 2018 performance period if the clinician or group falls below the low-volume threshold during the second determination period, which will include an assessment of Medicare Part B claims data from September 1, 2017 through August 31, 2018.

The MIPS Participation Status look-up tool will be updated to reflect eligibility information from the second determination period (September 1, 2017 – August 31, 2018) in late 2018.

What Do I Do Now?

- **If the clinician is eligible for MIPS, the clinician:**
  - Will choose whether to participate at the individual or group level.
    - **Exception**: MIPS eligible clinicians in a MIPS APM will participate at the MIPS APM entity level.
  - Will start to collect performance data for services furnished January 1 – December 31, 2018.
  - Will determine their submission mechanism(s) for the Quality, Promoting Interoperability (formerly Advancing Care Information), and Improvement Activities performance categories. (Note that advance registration is required for some submission mechanisms. More information is available on the QPP website.)
  - Will submit MIPS 2018 performance period data to Medicare no later than March 31, 2019.
    - Clinicians who are eligible for MIPS in the 2018 performance period but don't submit data will be subject to the maximum negative payment adjustment (-5%) in 2020.
  - Will receive a payment adjustment (positive, neutral, or negative), based on the data submitted, which will affect his or her 2020 Medicare Part B payments for covered professional services under or based on the Physician Fee Schedule (PFS).
- **If the clinician is not eligible for MIPS, the clinician:**
  - Will not receive a payment adjustment in 2020 under MIPS.
  - Is not required to take further action unless his or her TIN decides to participate as a group or Virtual Group, or is identified as a MIPS APM participant, and the group, Virtual Group, or MIPS APM entity is above the low volume threshold.
  - Can voluntarily participate in the program.

Voluntary Participation

Clinicians who do not meet the definition of a MIPS eligible clinician in Year 2 may choose to voluntarily submit data individually to Medicare to learn, to obtain feedback on Quality, Promoting Interoperability, and Cost measures, and to prepare in the event MIPS is expanded in the future. Clinicians who submit data voluntarily will not receive a payment adjustment.

Clinicians Practicing in Critical Access Hospitals, Rural Health Clinics, Federally Qualified Health Centers, Ambulatory Surgical Centers, Home Health Agencies, and Hospital Outpatient Departments

MIPS Participation for Clinicians Practicing in Critical Access Hospitals (CAHs)

Clinicians included in MIPS and practicing in CAHs are required to participate in MIPS unless they are deemed ineligible.

For MIPS eligible clinicians practicing in Method I CAHs, the MIPS payment adjustment would apply to payments made for covered professional services under the Physician Fee Schedule (PFS) that are Medicare Part B allowed charges billed by the MIPS eligible clinicians. The payment adjustment will not apply to the facility payment to the CAH itself.

For MIPS eligible clinicians practicing in Method II CAHs who have assigned their billing rights to the CAH, CMS would apply the MIPS payment adjustment to the Method II CAH payments. For MIPS eligible clinicians practicing in Method II CAHs that have not assigned their billing rights to the CAH, the MIPS payment adjustment would apply in the same way as for MIPS eligible clinicians who bill for covered professional services in Method I CAHs.

MIPS Participation for Clinicians Practicing in Rural Health Clinics (RHCs) or Federally Qualified Health Centers (FQHCs)

Clinicians practicing in RHCs or FQHCs who provide services that are billed exclusively under the RHC or FQHC payment methodologies are not required to participate in MIPS (they may voluntarily submit data on measures and activities under MIPS) and are not subject to a payment adjustment.

However, if these clinicians provide covered professional services and bill for those services separately under the Physician Fee Schedule (PFS), they would be required to participate in MIPS and the payment for covered professional services under the Physician Fee Schedule (PFS) would be subject to a payment adjustment. CMS will only use the covered professional services under the Physician Fee Schedule when determining eligibility for these clinicians.

MIPS Participation for Clinicians Practicing in Ambulatory Surgical Centers (ASCs), Home Health Agencies (HHAs), and Hospital Outpatient Departments (HOPDs)

Clinicians practicing in ASCs, HHAs, or HOPDs who provide services that are billed exclusively under the ASC, HHA, or HOPD payment methodologies are not required to participate in MIPS (they may voluntarily submit data on measures and activities under MIPS) and are not subject to a payment adjustment.

However, if these clinicians provide covered professional services and bill for those services separately under the Physician Fee Schedule (PFS), they would be required to participate in MIPS and the payment for covered professional services under the Physician Fee Schedule (PFS) would be subject to a payment adjustment. CMS will only use the covered professional services under the Physician Fee Schedule when determining eligibility for these clinicians.

Medicare Part B Clinicians – Who is Ineligible?

Several categories of Medicare Part B clinicians are ineligible for MIPS.

1. New Medicare-enrolled Clinicians

MIPS eligible clinicians who enroll in Medicare for the first time in 2018 are not required to submit MIPS measures and activities for the 2018 performance year. To be considered a new Medicare-enrolled eligible clinician, clinicians cannot have submitted claims to Medicare prior to January 1, 2018 under any other enrollment as an individual or through a group.

CMS will use data from the Provider Enrollment, Chain, and Ownership System (PECOS) to identify MIPS eligible clinicians who enrolled in Medicare for the first time on or after January 1, 2018. These clinicians are ineligible for MIPS in the 2018 performance year and will not receive a MIPS payment adjustment in 2020.

2. Clinicians, Groups, and MIPS APM Entities Below the Low-volume Threshold

We increased the low-volume threshold as part of our ongoing efforts to reduce clinician burden. The low-volume threshold is applied at the level in which the MIPS eligible clinician will participate in MIPS:

- For MIPS eligible clinicians participating as an individual, the low-volume threshold is determined at the individual level (for each practice association [TIN/NPI combination]).
- For MIPS eligible clinicians participating as part of a group, the low-volume threshold is determined at the group level (TIN), not the individual level.
- For MIPS eligible clinicians participating in a MIPS APM, the low-volume threshold is determined at the MIPS APM entity level, not at the individual or group level.

Individuals, groups and MIPS APM entities are below the low-volume threshold and ineligible for MIPS if they:

- Bill less than or equal to $90,000 in covered professional services for Medicare Part B Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer), OR
- Provide care for 200 or fewer Part B-enrolled Medicare beneficiaries.

For the 2017 performance period, low-volume threshold calculations were based on all Medicare Part B allowed charges and Part B services furnished to patients. However, the Bipartisan Budget Act of 2018 included a provision that affects how MIPS eligibility is determined with respect to the low-volume threshold.

Beginning with the 2018 performance year, these calculations will be based on covered professional services under the Physician Fee Schedule furnished to Part B beneficiaries.

2018 Performance Period Determinations

There are two low-volume threshold determination periods for the 2018 performance year, during which CMS reviews both historical and performance period claims data.

- Historical claims data: September 1, 2016 – August 31, 2017

- Performance period claims data: September 1, 2017 – August 31, 2018Low-volume Threshold for Individual Participation

The low-volume threshold is calculated twice for each individual clinician associated with a practice. (Clinicians are identified by their individual National Provider Identifier (NPI) and practices are identified by a Taxpayer Identification Number (TIN).)

For a clinician (NPI) who is associated with multiple practices (TINs), the low-volume threshold will be calculated twice for each practice associated with the clinician (TIN/NPI combination).

- MIPS eligible clinicians (identified by a TIN/NPI combination) who exceed the low-volume threshold in both determination periods will be required to participate in MIPS under that practice.
- MIPS eligible clinicians (identified by a TIN/NPI combination) who are below the low-volume threshold in either determination period will be ineligible to participate individually in MIPS under that TIN/NPI combination but can choose to voluntarily report.

Because eligibility is determined for each TIN/NPI combination, a MIPS eligible clinician associated with multiple practices may be required to participate in MIPS at one practice, and ineligible to participate as an individual at others.

Low-volume Threshold for Group Participation

The low-volume threshold will also be calculated for the group as a collective entity.

For a clinician (NPI) who is associated with multiple practices (TINs), the low-volume threshold will be calculated twice for each practice associated with the clinician (TIN/NPI combination).

- If a group (as a whole) is determined to exceed the low-volume threshold in both determination periods, then the group can participate in MIPS at the group level (i.e. submit TIN level data). If they choose to submit data as a group, all MIPS eligible clinicians in the group are included in MIPS and will receive a payment adjustment based on the group's performance, regardless of whether those clinicians exceed the low-volume threshold as individuals.
- If a group (as a whole) is below the low-volume threshold in either determination period, then the group is ineligible to participate in MIPS but can choose to voluntarily submit data. Clinicians in a group that submits data voluntarily will not receive a payment adjustment based on the group's performance.

Low-volume Threshold for Virtual Group Participation

Each group or solo practitioner electing to form a Virtual Group must exceed the low-volume threshold at the TIN level based on historical claims data (September 1, 2016 – August 31, 2017). Virtual Groups will not lose their eligibility if they fall below the low-volume threshold in the second determination period (September 1, 2017 – August 31, 2018).

Low-volume Threshold for MIPS Eligible Clinicians Practicing in MIPS APMs

Similar to the low-volume threshold applying at the group level, the low-volume threshold applies at the APM Entity level to MIPS eligible clinicians practicing as part of a MIPS APM Entity. For a MIPS APM Entity, the low-volume threshold will be calculated for the collective entity.

Example:
Track 1 Medicare Shared Savings Program ACO Entity is comprised of three Participant TINs (TINs A, B and C).

- TIN A bills $100,000 in PFS allowed charges and provides care for 100 Part B beneficiaries.
- TIN B bills $80,000 in PFS allowed charges and provides care for 200 Part B beneficiaries.
- TIN C bills $50,000 in PFS allowed charges and provides care for 80 Part B beneficiaries.

While each TIN is below the low-volume threshold, the ACO exceeds the low-volume threshold at the Entity level (TIN A + TIN B + TIN C).

- If the APM Entity (as a whole) is determined to exceed the low-volume threshold, then the MIPS eligible clinicians identified as participating in the MIPS APM Entity are required to participate in MIPS.
- If the APM Entity (as a whole) is determined to fall below the low-volume threshold, then the MIPS eligible clinicians identified as participating in the MIPS APM Entity are not required to participate in MIPS.

The exclusion will not affect eligible clinicians participating in an Advanced APM with Qualifying Participant (QP) or Partial Qualifying Participant (Partial QP) status.

3. Qualifying and Partial Qualifying Participants in Advanced APMs.

Clinicians who participate in an Advanced APM and are identified on the QPP Participation Status tool as Qualifying Participants (QPs) are not eligible for MIPS participation and will not receive a MIPS payment adjustment. Clinicians in an Advanced APM who are Partial Qualifying Participants (Partial QPs) may choose whether or not to submit data on MIPS measures and activities. If Partial Qualifying Participants do not choose to participate in MIPS, they are not required to participate in MIPS data submission and will not receive a MIPS payment adjustment.

Special Rules for MIPS Eligible Clinicians

In MIPS, there are special rules for certain types of clinicians. The following explains the requirements for participating in MIPS.

2018 Performance Period Determinations

Just as with low-volume threshold calculations, CMS reviews both historical and performance period claims data to identify clinicians, groups and Virtual Groups who are non-patient facing, in a rural area, in a Health Professional Shortage Area (HPSA), or in small practice.

- Historical claims data: September 1, 2016 – August 31, 2017

- Performance period claims data: September 1, 2017 – August 31, 2018

If a clinician, group or Virtual Group is identified as non-patient facing, in a rural area, in a HPSA, or in small practice in either determination period, they will retain this status for the performance period.

Please note that, though determinations are not based on performance period claims data, we will use the same determination periods to determine special status for hospital-based and ASC-based clinicians.

Non-patient Facing MIPS Eligible Clinicians, Groups and Virtual Groups

Clinicians who bill 100 or fewer patient-facing encounters (including Medicare telehealth services) during a determination period are considered non-patient facing. Groups are considered non-patient facing if more than 75 percent of its clinicians have 100 or fewer patient-facing encounters (including Medicare telehealth services). Virtual Groups are considered non-patient facing if more than 75 percent of its clinicians across all TINs have 100 or fewer patient-facing encounters (including Medicare telehealth services).

Non-patient facing clinicians, groups, and Virtual Groups are required to participate in MIPS but have reduced data submission requirements for the Improvement Activities performance category and qualify for automatic reweighting of the Promoting Interoperability performance category to 0% of the final score. These flexibilities are in place to account for cases where there are limited measures and activities applicable and available to these clinicians.

Hospital-based MIPS Eligible Clinicians, Groups, and Virtual Groups

Clinicians who furnish 75% or more of their covered professional services in off-campus outpatient hospital, inpatient hospital, on-campus outpatient hospital, or emergency room settings (as identified by place of service (POS) codes 19, 21, 22, 23) during a determination period are considered hospital-based. Groups and Virtual Groups are considered hospital-based if all (100%) of the MIPS eligible clinicians in the group or Virtual Group are determined to be hospital-based.

Hospital-based clinicians, groups and Virtual Groups are required to participate in MIPS but qualify for automatic reweighting of the Promoting Interoperability performance category to 0% of the final score.

Ambulatory Surgical Center (ASC)-based MIPS Eligible Clinicians, Groups, and Virtual Groups

Clinicians who furnish 75% or more of their covered professional services in ambulatory surgical centers (as identified by POS code 24) during the determination period are considered ASC-based. Groups and Virtual Groups are considered ASC-based if all (100%) of the MIPS eligible clinicians in the group or Virtual Group are determined to be ASC-based.

ASC-based clinicians, groups and virtual groups are required to participate in MIPS but qualify for automatic reweighting of the Promoting Interoperability performance category to 0% of the final score.

Please note that services furnished by a MIPS eligible clinician that are payable under the ASC, HHA, Hospice, or HOPD methodology are not subject to a MIPS payment adjustment, and such services will not be utilized for MIPS eligibility purposes.

Small Practices

A small practice is one with 15 or fewer clinicians billing under the TIN, including those who do not meet the definition of a MIPS eligible clinician or who are otherwise ineligible for MIPS. Solo practitioners are included in the definition of a small practice. A Virtual Group is identified as a small practice when there are 15 or fewer clinicians collectively billing under all the TINs in the Virtual Group.

MIPS eligible clinicians in small practices reporting as individuals, as well as those reporting as a group or Virtual Group, are required to participate in MIPS but have reduced data submission requirements for the Improvement Activities performance category. Beginning with the 2018 performance period, they may be eligible for reweighting their Promoting Interoperability performance category to 0% of the final score if they submit an application. They will also have bonus points added to their final score as long as they submit data for at least one performance category.

Rural Area and HPSA MIPS Eligible Clinicians, Groups and Virtual Groups

MIPS eligible clinicians are determined to practice in a rural area when the practice ZIP code is designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data set available; Health Professional Shortage Areas (HPSAs) are those areas designated under section 332(a)(1)(A) of the Public Health Service Act. Individual MIPS eligible clinicians and groups with multiple practices under its TIN would be designated as a rural or HPSA practice if more than 75 percent of NPIs billing under the individual MIPS eligible clinician or group's TIN, as applicable, are designated in a ZIP code as a rural area or HPSA. Virtual Groups with multiple practices under its TINs would be designated as a rural or HPSA practice if more than 75 percent of NPIs billing within the Virtual Group are designated in a ZIP code as a rural area or HPSA.

MIPS eligible clinicians, groups and Virtual Groups with a rural or HPSA designation are required to participate in MIPS but have reduced data submission requirements for the Improvement Activities performance category.

MIPS APM Participants

Eligible clinicians who participate in, but do not meet the threshold for sufficient payments or patients through, an Advanced APM in order to become QPs or Partial QPs that choose not to report, are MIPS eligible clinicians for the year unless they are excluded on some other basis. Those who participate in a MIPS APM are scored for MIPS under the APM Scoring Standard with its special data submission and scoring rules. Data submission and scoring rules can vary depending on the MIPS APM. MIPS eligible clinicians must be included on the Participant List for a MIPS APM on at least one of three snapshot dates – March 31, June 30, or August 31 – to be scored under the APM scoring standard.

A fourth snapshot date (December 31, 2018) was added for the 2018 performance year for full-TIN MIPS APMs (currently only those in the Medicare Shared Savings Program). If the MIPS eligible clinician is not on the MIPS APM Participation List on at least one of the three (or four) snapshot dates, then they should submit data to MIPS as an individual or group and will be scored using the general MIPS rules rather than the APM scoring standard.

Quality Payment Program Year 2: MIPS Policy Highlights

Working to Reduce Your Burden

To help program participants be successful, we continue to look for ways to reduce clinician burden. For Year 2 of the Quality Payment Program, many policies were adopted to further reduce clinician burden and give clinicians more ways to participate successfully such as by:

- Allowing the use of 2014 Edition and/or 2015 Edition Certified Electronic Health Record Technology (CEHRT) in Year 2, while offering a bonus in the Promoting Interoperability performance category (formerly Advancing Care Information) for using 2015 CEHRT exclusively.
- Adding up to 5 bonus points on your final score for the treatment of complex patients.
- Allowing clinicians facing extreme and uncontrollable circumstances automatic reweighting for all 4 performance categories.
- Introducing Improvement Scoring in the Quality performance category to reward improvement in this category from one year to the next.

Adding More Options for Small Practices

We realize it can be hard for small practices to participate in the Quality Payment Program, so we're continuing to offer tailored flexibilities for groups and Virtual Groups of 15 or fewer clinicians such as the following:

- Excluding individual MIPS eligible clinicians or groups with less than or equal to $90,000 in Part B allowed charges for covered professional services under the Physician Fee Schedule (PFS) or less than or equal to 200 Part B beneficiaries.
- Adding 5 bonus points to the final scores of small practices that submit data for at least one performance category.

- Giving solo practitioners and small practices the choice to form or join a virtual group to participate with other practices.
- Continuing to award small practices 3 points for measures in the Quality performance category that don't meet data completeness requirements.
- Adding a new hardship exception for the Promoting Interoperability performance category for small practices.

Gradual Implementation

CMS has continued many of its transition year policies while introducing modest changes for 2018. As we move towards full implementation of the Quality Payment Program, the policies below were finalized to ensure that clinicians are ready for full implementation in year 3. These policies include:

- Weighting the Cost performance category to 10% of the final score. For the 2018 performance period, the Cost performance category includes the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures. These two measures were based on measures used for the Value Modifier program and were used to provide feedback for the MIPS transition year. CMS will calculate cost measure performance based on administrative claims information; no additional data submission is required from clinicians.
- Increasing the performance threshold to 15 points in Year 2 (from 3 points in the transition year).
- Continuing a phased approach to public reporting Quality Payment Program performance information on Physician Compare.

Bipartisan Budget Act of 2018

The Bipartisan Budget Act of 2018, enacted on February 9, 2018, included several changes to the Merit-based Incentive Payment System (MIPS), including the following:

- Changes the application of the MIPS payment adjustments so that these adjustments will only apply to payments for Medicare Part B covered professional services under the Physician Fee Schedule (PFS). This will occur beginning in the 2019 payment year, which is the first year of application of the payment adjustments under MIPS. This will mean that the payment adjustments will not apply to payments for Medicare Part B drugs and other services for which payment is not made under or based on the Physician Fee Schedule.
- Changes the low-volume threshold calculation so that the calculations will now be based on Medicare Part B allowed charges for covered professional services under the Physician Fee Schedule (PFS) services furnished to patients.
- Allows for flexibility in the weight of the Cost performance category for three additional years. Instead of requiring that this performance category be 30 percent of the final score beginning in the third year of the program, the weight is now required to be not less than 10 percent and not more than 30 percent for the third, fourth and fifth years of the program.
- Delays implementation of improvement scoring for the Cost performance category until the sixth year of the program.

- Allows more flexibility in establishing the performance threshold for three additional years to ensure a gradual and incremental transition to the estimated performance threshold for the sixth year of the program. For this sixth year, the performance threshold will be the mean or median of the final scores for all MIPS eligible clinicians for a prior period specified by the Secretary.

Extreme and Uncontrollable Circumstances

Throughout 2017, numerous clinicians were affected in many areas of the country due to natural disasters including Hurricanes Harvey, Irma, Maria, and Nate, and the California wildfires. The extreme and uncontrollable circumstances policies for both the transition year and the 2018 MIPS performance period were established in the CY 2018 Quality Payment Program final rule with comment period and the Interim Final Rule with Comment period.

Starting with the 2018 MIPS performance period, if a MIPS eligible clinician is affected by extreme and uncontrollable circumstances (e.g., a hurricane, natural disaster, or public health emergency), the MIPS eligible clinician, group or virtual group may qualify for reweighting of any, or all, of the 4 performance categories (Quality, Cost, Promoting Interoperability, Improvement Activities).

- For information about extreme and uncontrollable circumstances in the Transition Year (2017 performance period), please refer to the Extreme and Uncontrollable Circumstances Policy for MIPS in 2017 Fact Sheet, which includes the 2017 automatic reweighting policy implemented for clinicians impacted by Hurricanes Harvey, Irma, Maria, and Nate, and the California wildfires.

21st Century Cures Act

Enacted in 2016, the 21st Century Cures Act contains provisions affecting the Promoting Interoperability performance category for the Quality Payment Program's 2017 transition year and future years. The 21st Century Cures Act was enacted after the publication of the CY 2017 Quality Payment Program final rule with comment period. In the CY 2018 Quality Payment Program final rule with comment period, CMS implemented provisions in the 21st Century Cures Act, some of which apply to the MIPS transition year including:

- Reweighting the Promoting Interoperability performance category to 0% of the final score for ambulatory surgical center (ASC)-based MIPS eligible clinicians.
- Using the 21st Century Cures Act authority for significant hardship exceptions and hospital-based MIPS eligible clinicians to reweight the Promoting Interoperability performance category to 0% of the final score.

Virtual Groups

For 2018, Virtual Groups were added as another participation option for Year 2. A Virtual Group is a combination of 2 or more Taxpayer Identification Numbers (TINs) made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter specialty or location) to participate in MIPS for a performance period of a year. While the election process has closed for Year 2, we're updating our Virtual Group Toolkit to assist solo

practitioners and groups interested in forming a virtual group for Year 3. The election process for Year 3 (2019 performance period) will open later this year and close on December 31, 2018.

Quality Payment Program: Comparing Final Policies in Year 1 and Year 2

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
MIPS POLICY		

Low-volume Threshold	• The low-volume threshold calculations included allowed charges for all Medicare Part B items and services.
	• You're ineligible if you or your group has ≤$30,000 in Part B allowed charges OR ≤100 Part B beneficiaries.
	• 2017 Performance Period Determinations
	  ○ Historical claims data: September 1, 2015 – August 31, 2016
	  ○ Performance period claims data: September 1, 2016 – August 31, 2017
		• The low-volume threshold calculations include PFS allowed charges for covered professional services furnished to patients.
		• You're ineligible if you or your group has ≤$90,000 in Part B PFS allowed charges for covered professional services OR ≤200 Part B FFS beneficiaries.
		• 2018 Performance Period Determinations
		  ○ Historical claims data: September 1, 2016 – August 31, 2017
		  ○ Performance period claims data: September 1, 2017 – August 31, 2018

Non-patient facing	• Individual - If you have ≤100 patient facing encounters. • Groups - If your group has >75% NPIs billing under your group's TIN during a performance period considered as non-patient facing.	• Individual and Group policy: No change for Year 2. • Virtual Groups have a similar definition as groups. Virtual Groups that have >75% NPIs billing under the Virtual Group's TINs during a performance period who are non-patient facing.

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
Hospital-based	• Individual – If you furnish 75% or more of your covered professional services in the inpatient hospital, on -campus outpatient hospital, or emergency room settings (as identified by place of service (POS) codes 21, 22, 23) during the applicable determination period.	• Revised the definition of hospital-based MIPS eligible clinician to include covered professional services furnished by MIPS eligible clinicians in an off-campus-outpatient hospital setting (as identified by Place of Service, or POS code 19). • No change to the percentage of covered professional services that must be furnished to be determined hospital-based
Ways to submit	• You will be scored on the data submitted through a single submission mechanism per performance category.	• No change for Year 2 • For Year 3, you will be able to use multiple submission mechanisms to meet the reporting requirements for a single performance category.
Virtual Groups	• Not an option for the transition year.	• Added Virtual Groups as a way to participate for Year 2. Virtual Groups 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 of a year. • Solo practitioners and small groups (10 or fewer NPIs) must exceed the low-volume threshold at the TIN level to participate.

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)

		• The MIPS payment adjustments will only apply to the MIPS eligible clinicians in a Virtual Group.
		• If a group chooses to join or form a Virtual Group, all eligible clinicians under the TIN would have their performance assessed as part of the Virtual Group.
		• Components are finalized for a formal written agreement between each member of the Virtual Group.
		• Each Virtual Group will be identified by a unique Virtual Group identifier, which must be provided to any vendors submitting performance data on their behalf, such as qualified registries, QCDRs, and/or EHRs.
		• If certain members of a Virtual Group are in a MIPS APM, we'll apply the APM Scoring Standard instead of the Virtual Group score.
		• Generally, policies that apply to groups would apply to virtual groups. Differences include the way the following designations apply at the virtual group level:
		  ○ Non-patient facing
		  ○ Small practice

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
		○ Rural area and Health Professional Shortage Area ○ Hospital-based and ASC-based Please note that the Virtual Group election process for Year 2 closed on December 31, 2017.
Facility-based measurement	• Not available in current transition year.	• Not available in Year 2. Due to operational constraints, the facility-based measurement proposal was delayed until Year 3 of the Quality Payment Program (2019 performance year and 2021 payment year).
Quality	**Weight to final score:** • 60% in Year 1 (2019 payment year).	**Weight to final score:** • 50% in Year 2 (2020 payment year).
	Data completeness: • 50% for submission mechanisms except for Web Interface and CAHPS. • Measures that don't meet the data completeness criteria earn 3 points.	**Data completeness:** • 60% for submission mechanisms except for Web Interface and CAHPS. • Measures that don't meet the data completeness criteria will earn 1 point, except for measures submitted by a small practice, which will continue to earn 3 points.

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	Scoring: • 3-point floor for measures scored against a benchmark. • 3 points for measures that don't have a benchmark or don't meet case minimum requirements. • Bonus for additional outcome or high priority measures up to 10% of denominator for performance category. • Bonus for end-to-end electronic reporting up to 10% of denominator for performance category.	**Scoring:** • No change to these policies for Year 2 (2020 payment year) • Added Improvement Scoring (please refer to the Improvement Scoring section for more information)
Quality/ topped out quality measures	• Not applicable for the transition year.	• Topped-out measures will be removed and scored on four year phasing out timeline. • Topped out measures with measure benchmarks that have been topped out for at least two consecutive years will earn up to seven points. • A seven-point scoring policy for six topped out measures identified for the 2018 performance period was finalized. These six topped out measures are: ○ Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin.

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
		(Quality Measure ID: 21) ○ Melanoma: Overutilization of Imaging Studies in Melanoma.(Quality Measure ID: 224) ○ Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients). (Quality Measure ID: 23) ○ Image Confirmation of Successful Excision of Image-Localized Breast Lesion. (Quality Measure ID: 262) ○ Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description (Quality Measure ID: 359) ○ Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy (Quality Measure ID: 52) • Topped out policies do not apply to CMS Web Interface measures, and we will monitor for

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
		differences with other submission options. • CAHPS for MIPS survey will be addressed in future rulemaking.
Improvement scoring for Quality	• Doesn't apply in the 2017 transition year.	• We'll measure improvement at the performance **category** level. • Up to ten percentage points will be available for improvement scoring in the Quality performance category. • CMS will calculate an improvement score only when there's sufficient data to measure improvement (e.g., MIPS eligible clinician uses the same identifier in two consecutive performance periods and is scored on the same cost measure(s) for two consecutive performance periods). • If the improvement score can't be calculated because there is not sufficient data, or if there is no improvement, we'll assign an improvement score of 0 percentage points. **Note:** The CY 2018 Quality Payment Program Final Rule with Comment period had finalized improvement scoring for the cost category in Year

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
		2, but the Bipartisan Budget Act of 2018 delays implementation of this policy until Year 6.
Cost	**Weight to final score:** • 0% in Year 1 (2019 payment year).	**Weight to final score:** • 10% in Year 2 (2020 payment year).
	Measures: • Includes the Medicare Spending per Beneficiary (MSPB), total per capita cost measure, and ten episode-based measures.	**Measures:** • Includes the Medicare Spending per Beneficiary (MSPB) and total per capita cost measure. • For the 2018 MIPS performance period, we won't use the ten episode-based measures adopted for the 2017 MIPS performance period. • New episode-based measures are being developed with stakeholder input and will be soliciting feedback on some of these measures fall 2018. • We expect to propose new cost measures in future rulemaking and solicit feedback on episode-based measures before they are included in MIPS.
	Submission/Scoring: • We'll calculate an individual MIPS eligible clinician's and group's Cost performance category score using administrative claims data	**Submission/Scoring:** • No change to these policies for Year 2.

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	if they meet the case minimum of attributed patients for a measure and if a benchmark has been calculated for a measure. • Individual MIPS eligible clinicians and groups don't have to submit any other information for the Cost performance category. • We compare your performance with the performance of other MIPS eligible clinicians and groups during the performance period so measure benchmarks aren't based on a previous year. • Performance category score is the average of the measures. • If only 1 measure can be scored, that score will be the performance category score.	
Improvement Activities	**Weight to final score:** • 15% and we measure it based on a selection of different medium and high weighted activities**.**	**Weight to final score:** • No change for Year 2
	Number of activities: • We included 92 activities in the Inventory. • Small practices; practices in rural areas, geographic health professional	**Number of activities:** • Finalized more activities and changes to existing activities for a total of 112 activities in the Inventory.

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	shortage areas (HPSAs); and non-patient facing MIPS eligible clinicians don't need more than two activities (two medium or one high-weighted activity) to earn the full score. • All other MIPS eligible clinicians don't need more than 4 activities (4 medium or 2 high-weighted activities, or a combination).	• Requirements for small practices, practices in rural areas, geographic HPSAs, and non-patient facing MIPS eligible clinicians: no change. • No change in the number of activities that you need to report to reach a maximum of 40 points.
	Definition of certified patient-centered medical home: • Includes accreditation as a patient-centered medical home from 1 of 4 nationally-recognized accreditation organizations; a Medicaid Medical Home Model or Medical Home Model; NCQA patient-centered specialty recognition; and certification from other payer, state or regional programs as a patient-centered medical home if the certifying body has 500 or more certified member practices. • Only 1 practice within a TIN has to be a patient-centered medical home or comparable specialty practice for the TIN to get full credit in the category.	**Definition of certified patient-centered medical home:** • We've finalized the term "recognized" to mean the same as "certified" as a patient-centered medical home or comparable specialty practice. • We've finalized a 50% threshold for 2018 for the number of practice sites (physical locations) within a TIN that need to be patient-centered medical homes for that TIN to get full credit for the Improvement Activities performance category.

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	Submission/Scoring: • All APMs get at least 1/2 of the highest score, but we'll give MIPS APMs an additional score, which may be higher than one half of the highest potential score based on their model. All other APMs must choose other activities to get additional points for the highest score. • Some activities qualify for Advancing Care Information bonus. • For group participation, only 1 MIPS eligible clinician in a TIN has to perform the Improvement Activity for the TIN to get credit. • Clinicians and group attest to the completion of activities.	**Submission/Scoring:** • No change to the scoring policy for APMs and MIPS APMs. • There are more activities (a total of 31) in the performance category that also qualify for a Promoting Interoperability bonus. • For group participation, only 1 MIPS eligible clinician in a TIN has to perform the Improvement Activity for the TIN to attest to it. • We continue to allow simple attestation of Improvement Activities.
Promoting Interoperability (formerly Advancing Care Information)	**Weight to final score:** • 25%, made up of a base score, performance score, and bonus score, based on data submitted for objectives and measures.	**Weight to final score:** • No change for Year 2
	CEHRT requirements: • Can use either 2014 or 2015 Edition CEHRT for the 2017 transition year.	**CEHRT requirements:** • No change for Year 2 • A 10% bonus is available if you use the 2015 Edition CEHRT exclusively.

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	Scoring: • Earn a base score of 50% if you submit the numerator (of at least "one") and denominator, or "yes" for the yes/no measure, for each required measure or claim an exclusion. If the base score isn't met, you'll get a zero for the Promoting Interoperability performance category. • Earn performance score points if you submit additional measures (up to 10% or 20% each). • Earn a bonus score (5%) for reporting to one or more additional public health agencies or clinical data registries beyond the Immunization Registry Reporting measure. • Earn a bonus score (10%) when you use CEHRT to complete at least 1 of the specified Improvement Activities.	**Scoring:** • No change to the **base** score requirements for Year 2 (2020 payment year) • For the **performance** score, you or your group may earn up to 10% for reporting to any single public health agency or clinical data registry. (For group data submission, this means at least one MIPS eligible clinician is actively engaged with the agency or registry.) • A 5% **bonus** score is available for reporting to an additional public health agency or clinical data registry other than the one submitted for the performance score. (For group data submission, this means at least one MIPS eligible clinician is actively engaged in with the agency or registry.) • A 10% Promoting Interoperability **bonus** is available if you use CEHRT to complete at least one of the 31 specified Improvement Activities eligible for the CEHRT bonus. • A 10% **bonus** score for using 2015 Edition CEHRT exclusively to report the Promoting

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
		Interoperability Measures and Objectives (Promoting Interoperability Transition Objectives and Measures that are reported using 2015 Edition CEHRT are not eligible for this bonus).
	Exceptions: • We reweighted the Advancing Care Information performance category to 0% of the final score and reallocated the weight to the Quality performance category if there are not sufficient measures applicable and available for a clinician, as demonstrated through an application process or through automatic reweighting.	**Exceptions:** • We'll reweight the Promoting Interoperability performance category to 0% of the final score and reallocate the performance category weight of 25% to the Quality or Improvement Activities performance categories for: ○ An approved significant hardship exception request or automatic exception. ○ A new significant hardship exception available by request for MIPS eligible clinicians in small practices (15 or fewer clinicians); ○ A new significant hardship exception available by request for MIPS eligible clinicians whose EHR was decertified. ○ An automatic exception for hospital-based MIPS eligible clinicians (updated definition to include POS 19); and

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
		○ A new automatic exception for Ambulatory Surgical Center (ASC)-based MIPS eligible clinicians, to apply beginning with the transition year; • We won't apply a five-year limit to significant hardship exceptions • New deadline of December 31 of the performance period for the submission of reweighting applications, beginning with the 2017 performance period.
	Exceptions for Measures and Objectives: • Exclusions for the E-Prescribing and Health Information Exchange Measures, applicable in the transition year.	**Exceptions for Measures and Objectives:** • No changes for the Year 2 policy.
Complex patients bonus	• Not available in the current transition year.	• Clinicians can earn up to five bonus points towards their final score for the treatment of complex patients, based on a combination of the Hierarchical Condition Categories (HCCs) and the number of dually eligible patients treated.
Small practice bonus	• Not available in current transition year.	• We will add five points to the final score of any MIPS eligible clinician or group who's in a small

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
		practice (defined as 15 or fewer eligible clinicians), as long as the MIPS eligible clinician or group submits data for at least one performance category in an applicable performance period.
Final score	**2017 MIPS performance period final score:** • Performance category weight: Quality 60%, Cost 0%, Improvement Activities 15%, and Advancing Care Information 25%.	**2018 MIPS performance period final score:** • Performance category weight: Quality 50%, Cost 10%, Improvement Activities 15%, and Promoting Interoperability 25%.
Performance threshold/ Payment adjustment	• Performance threshold is set at three points. • Additional performance threshold set at 70 points for exceptional performance. • Payment adjustment for the 2019 payment year ranges from - 4% to + 4% (x scaling factor not to exceed 3) as required by law. • Additional payment adjustment for exceptional performance starts at 0.5% and goes up to 10% x scaling factor not to exceed 1. • Under provisions in the Bipartisan Budget Act of 2018, payment adjustments will apply only to covered professional Physician	• We've increased the performance threshold to 15 points. • Additional performance threshold stays at 70 points for exceptional performance. • Payment adjustment for the 2020 payment year ranges from - 5% to + 5% (x scaling factor not to exceed three) as required by law. • Additional payment adjustment calculation is the same as in 2017.

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	Fee Schedule (PFS) services furnished under Part B; payment adjustments will not apply to payments for Medicare Part B drugs and other non-covered professional services under the PFS.	
Performance period	• Minimum 90-day performance period for Quality, Advancing Care Information, and Improvement Activities. • Exception: measures through CMS Web Interface, CAHPS, and the readmission measure are for 12 months. • We'll measure Cost for 12 months.	• No change for Promoting Interoperability, Improvement Activities, and Cost performance periods. • Minimum 12-month performance period for Quality. • No change to the exception.
MIPS APM/APM SCORING STANDARD POLICY		
Identifying MIPS APM participants	• A clinician on the Participation List for a MIPS APM on at least one of the APM participation assessment (Participation List "snapshot") dates will be scored using the APM scoring standard for the applicable performance year. If you aren't on the Participation List for the MIPS APM on at least one of the snapshot dates (March 31, June 30, or August 31), then you'll need to submit data to MIPS using the MIPS	• We are adding December 31 as a fourth snapshot date beginning in 2018 only to determine participation in Full-TIN MIPS APMs (currently applies only for those in the Medicare Shared Savings Program). • We do not use the fourth snapshot date to make QP determinations or extend the QP performance period past August 31.

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
	individual or group participation option and meet all generally applicable MIPS data submission requirements in order to avoid a negative payment adjustment.	
Virtual Groups & MIPS APMs	• Not applicable for the transition year.	• For MIPS APMs, we're waiving sections of the statute that require all Virtual Group participants to receive their MIPS payment adjustment based on the virtual group score. This means that participants in MIPS APM Entities who are also participating in a Virtual Group would receive their MIPS payment adjustment based on their APM Entity score under the APM scoring standard.
Quality	• Use quality measure data reported through the APM. • 50% weight for Medicare Shared Savings Program ACOs, Next Generation ACO Model in the first year. • 0% weight for other MIPS APMs in the first year.	• Use quality measure data submitted through the APM. • Performance category weight = 50% for all MIPS APMs. • Quality Improvement points will be available beginning in the 2018 performance year for any APM Entity for which 2017 quality performance data are available.

POLICY TOPIC	TRANSITION YEAR (YEAR 1) (Final Rule CY 2017)	YEAR 2 (Final Rule CY 2018)
Improvement Activities	• 20% weight for Medicare Shared Savings Program ACOs, Next Generation ACO model. • 25% weight for other MIPS APMs for first year. • We'll automatically assign Improvement Activity scores based on APM design (no data submission required). We'll review each MIPS APM on a case-by-case basis, identify activities that are part of the design of the APMs that go with Improvement Activities, and assign the correlating Improvement Activity score to the APM Entity group.	• The Improvement Activities performance category weight = 20%.
Promoting Interoperability (formerly Advancing Care Information)	• We've weighted the Advancing Care Information performance category for the 2017 performance period at 30% for the Medicare Shared Savings Program and the Next Generation ACO Model MIPS APMs. • For all other MIPS APMs we've weighted this performance category at 75% for the 2017 performance period.	• The Promoting Interoperability performance category weight = 30%.
Cost	• The Cost performance category weight = 0%.	No change.

Contact Us

The Quality Payment Program can be reached at 1-866-288-8292 (TTY 1-877-715- 6222), Monday through Friday, 8:00 AM-8:00 PM Eastern time or by email at: QPP@cms.hhs.gov.

For more information, go to: qpp.cms.gov