Attachment B: Important Questions & Answers

What is the Quality Payment Program?

The Quality Payment Program was established following the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA ended the Sustainable Growth Rate formula, which threatened clinicians participating in Medicare with potential payment cliffs for 13 years. The Quality Payment Program improves Medicare by incentivizing clinicians to improve quality, reduce cost and use certified electronic health record (EHR) technology with the goal of making patients healthier. If you provide items and services under Medicare Part B, you are part of the dedicated team of clinicians who serve more than 55 million Medicare beneficiaries. You can choose how you want to participate based on your practice size, specialty, location, or patient population.

The Quality Payment Program has two tracks:

- The Merit-based Incentive Payment System (MIPS), or
- Advanced Alternative Payment Models (APMs)

What is MIPS?

MIPS is a new payment program, which combines aspects of the three "Legacy Programs" in which many clinicians have been participating to date into a single, improved system. These "Legacy Programs" include:

- Physician Quality Reporting System (PQRS)
- Physician Value Modifier (VM) program, and
- Medicare EHR Incentive Program

Under MIPS, you submit clinical and other data, which CMS uses to determine your performance-based adjustments to payments.

The first performance period of MIPS is 2017, and the first payment year is 2019. This means that your data in calendar year 2017 will be used to determine your MIPS adjustment to Medicare Part B payments for items and services provided in 2019. During 2017, you'll record certain quality data and how you used technology to support your practice. To potentially earn a positive payment adjustment in 2019, you should send in your data to Medicare no later than March 31, 2018.

Visit qpp.cms.gov to learn more about MIPS, including what data you need to submit and how.

Who is included in MIPS?

You're included in MIPS if you bill Medicare Part B more than $30,000 a year in allowable charges and provide care for more than 100 Medicare patients a year, and are a:

- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist

If 2017 is your first year participating in Medicare, then you're not eligible for MIPS participation.

What is Pick Your Pace?

Given the wide diversity of clinical practices, the initial development period of the Quality Payment Program implementation will allow you to pick your pace of participation for the first performance period that began January 1, 2017. If you are participating in MIPS you will have three flexible options to submit data to MIPS and a fourth option to join an Advanced APM in order to potentially become a Qualifying APM Participant. This will ensure that you do not receive a negative payment adjustment in 2019. If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment. If you submit 90 days of 2017 data to Medicare, you may earn a neutral or positive payment adjustment. If you submit a full year of 2017 data to Medicare, you may earn a positive payment adjustment. Visit qpp.cms.gov to learn more about Pick Your Pace.

I want to start preparing for MIPS, what should I do now?

Visit qpp.cms.gov to find a number of resources to help clinicians prepare for participating in the Quality Payment Program.

To get started, clinicians should consider the options for participation including the following key actions:

(1) Determine your eligibility and if your TIN participates in an Accountable Care Organization (ACO)
(2) Choose whether you want to submit data as an individual or as part of a group. If you are in an ACO, you can work with the person or entity within the ACO who reports quality on your behalf to make sure it has all necessary information.
(3) Choose your submission mechanism and verify its capabilities.
(4) Verify your EHR vendor or registry's capabilities before your chosen performance period.
(5) Choose your measure(s) and activities and pick your pace.
(6) Verify the information you need to report successfully.
(7) Record data based on your care for patients.
(8) Submit data.

I participate in the Medicare Shared Savings Program (SSP) Track 1. What do I do?

If your TIN is in a Track 1 SSP ACO you are subject to MIPS under MIPS special APM rules, including if your TIN bills $30,000 or less. You should continue to work with your ACO to meet your APM requirements. You can confirm your participation by visiting qpp.cms.gov where you can also learn about special scoring benefits.

How was my eligibility determined?
Your eligibility was determined based on Medicare Part B claims data from September 1, 2015 through August 31, 2016. If you are an eligible clinician type and submitted allowed charges for claims in this timeframe above the low-volume threshold, you are included in MIPS.

What is the low-volume threshold?
Practices or individuals with less than or equal to $30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare patients, are exempt from MIPS participation due to the low-volume threshold.

Is it possible for my group to be below the threshold?
Yes, it is possible for some groups to be below the threshold and, therefore, would not have to report.

Should our practice report as a group or as individuals? Where can I get more help to make the best choice?
Practices should visit qpp.cms.gov to find more information related to the participation options under MIPS.

How do I know if I'm in an Advanced APM and therefore possibly exempt from MIPS?
CMS will take three "snapshots" throughout the performance year to determine which eligible clinicians are participating in an Advanced APM and whether they meet the payment or patient thresholds to become Qualifying APM Participants (QPs). Reaching the QP threshold at any one of the three QP determinations will result in QP status for the eligible clinicians in the Advanced APM Entity. These snapshots will take place on approximately March 31, June 30, and August 31. CMS will provide notification of QP status before January 1, 2018.

Qualifying APM Participants will earn an APM incentive payment and be exempt from MIPS reporting requirements and payment adjustments because sufficient participation in an Advanced APM is achieved. You can visit **http://go.cms.gov/APMlist** to find the latest list of Advanced APMs for 2017.

I'm in an APM, but you've informed me that I'm in MIPS. What am I supposed to do?

All eligible clinicians are in MIPS unless we determine at one of the snapshot points during the performance year that participation in an Advanced APM is sufficient (in terms of payments or patient thresholds) to be a Qualifying APM participant (QP), or to be a Partial Qualifying APM participant (and an election is made not to report to MIPS). If you are in an APM that is not an Advanced APM, you may be eligible for special APM scoring under MIPS, which is designed to recognize your APM participation efforts and performance as well as minimize reporting burden. Please make sure you meet APM quality reporting requirements, including, where applicable, working with your ACO that will report quality data for MIPS on your behalf for the quality performance category. You may be required to submit certain information apart from the APM, for example, information for the Advancing Care Information category. You can contact the Quality Payment Program to understand the special benefits you have through your APM that will help you be successful in MIPS.

I'm in an APM, but you've informed me that I'm not eligible for MIPS. Should I continue participating in the APM?

Yes! You should continue to fulfill your APM's requirements. The Quality Payment Program does NOT change how any particular APM operates or rewards value, and APMs have their own quality reporting and participation requirements. Visit your APM's website to learn more about your requirements.

What is CMS doing to reduce burden of implementing such a big change in the next year?

CMS recognizes the concerns from stakeholders and as a result, we have established various options for clinicians to participate in the Quality Payment Program during the first performance year, which began on January 1, 2017. The participation options provide clinicians with a range of flexibility to select a pace that best meets the needs of their practice. As we strive to reduce the burdens clinicians may experience during their participation in the Program, we are committed to continuously streamlining and improving the various processes for 2018 and future years. Stakeholder engagement and feedback is critical to the rulemaking process and Program implementation. We look forward to receiving your comments regarding the CY 2018 Quality Payment Program proposed rule that will be published later this year.

What if I believe the information provided in Attachment A is inaccurate?

Please contact the Quality Payment Program at QPP@cms.hhs.gov or 1-866-288-8292 (Monday-Friday 8AM-8PM ET). **TTY** users can call 1-877-715-6222.