Medicare Quality Payment Program (QPP)

MIPS Action Plan: Supplementary FAQs for 2017

AMA
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MIPS Action Plan: Supplementary FAQs for 2017

This document supplements the AMA's MIPS Action Plan – 10 Key Steps for 2017 and provides additional information to address more detailed questions that may arise as you work through the various steps. For more AMA Medicare payment resources, see ama-assn.org/medicare-payment.

Step 1: Determine Whether MIPS Applies to You

Your first step is to determine whether or not the Merit-Based Incentive Payment System (MIPS) applies to you. All Medicare Part B participating physicians and some non-physician practitioners, including Physician Assistants (PAs), Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), and Certified Registered Nurse Anesthetists (CRNAs), are potentially subject to MIPS payment adjustments. However, many clinicians will be exempt because they:

- Are new to the Medicare program, meaning generally that you submitted Medicare claims for the first time in 2017.
- See 100 or fewer unique Medicare patients annually.
- Bill $30,000 or less in allowable charges to Medicare annually.
- See a significant percentage of their patients through a care delivery model that the Centers for Medicare & Medicaid Services (CMS) has deemed an Advanced Alternative Payment Model (AAPM) for purposes of the Quality Payment Program (QPP).

You or your group practice should have received a letter from CMS or your Medicare Administrative Contractor (MAC) in spring 2017 that further detailed these exemption criteria and CMS' assessment of whether or not you are a MIPS participant (or "MIPS-eligible"). CMS also has a MIPS eligibility determination look up tool that allows you to enter your National Provider Identifier (NPI) and see whether you are MIPS-eligible or excluded. The AMA's Payment Model Evaluator is also a good resource to evaluate participation and how you may be affected financially.

Know your practice:

- **Determine how long you've been enrolled in Medicare and your Medicare volume.**
- **Identify all MIPS-eligible clinicians in your practice.**
- **Check MIPS eligibility look up tool and CMS correspondence on MIPS eligibility.**
- **If you practice in an AAPM and think you might be MIPS-exempt, inquire with your AAPM administrator to determine whether you may be MIPS-exempt, or if special reporting rules apply. You may be exempt if you see a significant number of patients through a qualifying AAPM in 2017.**

Q1. I see that I am "MIPS-eligible." What does that mean?

If you are determined to be "MIPS-eligible," it means that you must participate in MIPS to avoid a 4% penalty unless you meet an exception such as participation in an AAPM.

Q2. I am a solo physician; am I still in MIPS?

Yes. Solo physicians are subject to the same rules as all other physicians who participate in Medicare Part

B. However, if you see 100 or fewer Medicare patients annually, or bill $30,000 or less in allowable charges annually, you may be excluded.

Alternatively, if you participate in a qualifying AAPM, you may also be excluded. In 2017, the following programs are qualifying AAPMs:

- Comprehensive ESRD Care (CEC) – Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program – Track 1+
- 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)

Q3. I don't see many Medicare patients, so I think I might be under the volume threshold and exempt from MIPS. How can I make sure?

CMS has reviewed your claims data from September 1, 2015 – August 31, 2016 and sent out correspondence in spring 2017 that included the agency's assessment of whether you will be a MIPS participant for the 2017 MIPS performance period. Their assessment is based on group and individual Taxpayer Identification Numbers (TINs) and TIN/NPI combinations. You can also verify whether you are exempt from MIPS through CMS' MIPS-eligibility look up tool.

CMS will conduct a second review of your data for the time period of September 1, 2016 – August 31, 2017 to identify additional 2017 program year MIPS-eligible individuals and groups. We expect that CMS will conduct this second low-volume analysis in fall 2017, but the agency has provided limited information on when it will communicate the results of its analysis.

Q4. Even though I personally see fewer than 100 Medicare patients and/or bill less than $30,000, my practice exceeds those thresholds and plans to report to MIPS as a group. Am I still exempt?

No, you are not exempt, because your practice plans to report as a group and, in this case, CMS will look at volume and reimbursement at the group TIN level. The benchmark applies to the group as a whole, and you will be subject to MIPS unless you meet a different exception (e.g. new to Medicare or risk-bearing AAPM participant). Note that CMS will determine whether each TIN (i.e., group) or TIN/NPI combination (i.e., individual billing under the group) meets the low-volume threshold as part of its initial determination. You and your practice may want to use this information to determine whether to report as an individual or as a group.

Q5. Must I meet the same requirements as a physician practicing in the ambulatory/office setting if I'm a hospital-based physician?

A hospital-based physician is subject to all of the same MIPS rules as a physician practicing in other settings except that he or she is not scored on the Advancing Care Information (ACI) category. Instead, hospital-based physician's MIPS score will be based on Quality and Improvement Activities (IA) in 2017. Also in 2017, CMS will use administrative claims data to calculate cost measure results and will report those results to you for informational purposes only.

Q6. How do I determine if I am a hospital-based physician?

You are considered "hospital-based" if you provided at least 75% of your Medicare professional services in an inpatient hospital, on-campus outpatient, or emergency department setting. CMS bases its determination on claims from a period prior to the performance year (for 2017, CMS has stated that period would be September 1, 2015 – August 31, 2016).

Q7. I do not have traditional face-to-face encounters with patients (radiology, pathology and anesthesiology). Must I meet the same requirements as a physician who sees patients face-to-face?

No, a non-patient facing individual or group is subject to fewer requirements under the MIPS, including:

- Excluded from most cost measures (if and when the Cost category is implicated following 2017).
- ACI category weighted to zero.
- Fewer requirements to satisfy the IA category.

A physician is "non-patient facing" if he or she provides 100 or fewer "patient-facing" encounters (such as office visits or surgical procedures); a group is "non-patient facing" if at least 75% of eligible clinicians in the group are non-patient facing. CMS' list of patient-facing encounter codes is available here.

Q8. I am part of a Medicare ACO. Will I still be subject to MIPS?

If you participate in a Track 1 ACO, you will still be subject to MIPS, but your ACO will handle your MIPS reporting. Physicians participating in most other

Medicare ACO models are eligible to qualify as AAPM participants and be exempt from MIPS if they see a sufficient number of patients or receive a sufficient percentage of their revenue through that AAPM). In either case, you should verify that you are on your ACO's participant list.

STEP 2 – Review Available Performance Categories

Quality, Advancing Care Information (ACI), and Improvement Activities (IA) are the three MIPS components available to clinicians to describe their 2017 performance and help determine future Medicare payment adjustments. The transition track you choose for 2017 (Minimum, Partial, or Full) will determine the number of measures from each category that you must submit.

In 2017, Quality accounts for 60% of the total MIPS score, ACI comprises 25%, and IA is worth 15%. For 2017, CMS is not using the cost category to score performance. If you are exempt from ACI reporting requirements (see below), the points that would have gone to ACI are shifted to Quality. In this case, Quality will be worth 85% of your total score, and IA will be worth 15%.

Know your practice:

- **Think about which of these components will help you meet your 2017 transition track's reporting requirements.**
- **Consider whether you have the reporting mechanism you need to submit the measures you want.**
- **Take note of the scoring methodology of each performance category to identify the right measures (for example, the medium- and high-weighted IA activities) to help you earn the best MIPS score possible.**

A. Quality

Q9. What is the Quality category? Is this the easiest category to report on this year?

Quality accounts for over half of your MIPS score in 2017 and builds on prior PQRS reporting experiences.

Q10. How can I earn the maximum points in the quality category?

To earn the maximum MIPS points, you select up to six measures from this category, including one outcome measure on 50 percent of applicable patients. If there is no applicable outcome measure then you should select another high priority measure. If reporting quality through the EHR, Qualified Registry, or Qualified Clinical Data Registry (QCDR) you must report on all patients, regardless of payer. If reporting through claims, you just report on Medicare Part B patients. CMS has adopted and provided a list of nearly 300 possible Quality measures to choose from, of which, 168 are high priority. Examples include acknowledging receipt of specialist report or documentation of current medications in the medical record. It is possible to earn a limited number of additional "bonus points" by reporting additional high priority measures.

Individuals or groups using a Qualified Clinical Data Registry (QCDR) may report approved "non-MIPS" measures to obtain credit in the quality performance category. Each QCDR may offer different "non-MIPS" measures, so you should refer to your applicable QCDR to identify the measures that you would report on. The QCDR specific measures are separate and apart from those listed on CMS' website.

Groups that use the CMS Web Interface must report 15 Quality measures for a full year.

Q11. What kind of measures should I select?

It is recommended that you choose measures that:

1. Are most representative of your practice, such as those that apply to the patients you see or the procedures that you perform frequently to ensure you have a minimum of 20 cases.
2. Review the list of measures and the associated CMS developed benchmarks to determine the amount of points you may earn on a measure.
3. If possible, avoid reporting on "topped out" quality measures, because you may have to achieve nearly the highest possible score on the measure to receive more than the minimum number of points for that measure.
4. Keep in mind that if you report on a new measure and CMS cannot develop a benchmark for the measure, the maximum number of points you can obtain on the measure is three.

"Topped out" measures are quality measures in which respondents generally perform well across the board.

Statistically, there is little to no difference in how eligible clinicians rank in their performance of these measures, suggesting little room for significant future improvements. CMS' has a list of topped out measures for your reference.

Q12. I am new to reporting Quality measures and don't think I can participate in submitting six measures. Will I get the 4% payment penalty?

In the 2017 participation year, you can avoid a penalty by reporting on at least one Quality measure for one patient at any point in the year. Alternatively, you can report on the ACI or IA categories; but, for many physicians, submitting one Quality measure is likely the easier course.

B. Advancing Care Information (ACI)

Q13. What is the Advancing Care Information (ACI) category?

ACI replaces CMS' "Meaningful Use" program and accounts for a quarter of your 2017 MIPS score. Just like Meaningful Use, ACI is predicated on use of Certified Electronic Health Technology (CEHRT). For 2017, participants may use 2014 or 2015 Edition CEHRT. You will report on the ACI measures that correspond to the Edition of CEHRT you are using.

There are two measure sets: "Advancing Care Information Objectives and Measures" and "2017 Advancing Care Information Transition Objectives and Measures." The latter is the 2017 transition set, which is available to both users of 2014 and 2015 Edition CEHRT. More information on these measure sets is available on CMS' Quality Payment Program website.

Q14. Do I have to report ACI measures to avoid a penalty?

No. Under the 2017 pick-your-pace requirements, eligible clinicians can avoid a penalty by reporting one Quality measure or one IA measure; if they do so, they do not have to report on any ACI measures.

Q15. What are the measures for the ACI category? Are they the same as Meaningful Use?

The ACI category uses Meaningful Use (MU) measures but is scored differently. The program divides measures into a base and performance score (each worth 50%) of the ACI score. You must report all of the base measures to earn any credit in the ACI category, and will earn additional partial credit for reporting measures above the base measures.

Q16. What are the ACI base measures and how are they scored?

To earn credit in the ACI category you must report on all of the base measures. Required Base measures in the 2017 data set are:

Security Risk Analysis	e-Prescribing
Provide Patient Access	Health Information Exchange

You only need to attest to the Security Risk Analysis and report on one patient for each of the remaining base measures to receive credit in the base score.

Q17. What are the ACI performance measures?

In addition to the Base measures, you can earn additional points with ACI Performance measures. Seven ACI Performance measures in the 2017 transition set:

Syndromic Surveillance Reporting	Secure Messaging
Specialized Registry Reporting	Medication Reconciliation
View, Download, or Transmit (VDT)	Immunization Registry Reporting
Patient-Specific Education	

Q18. Some of the performance measures look like they're doable, but others are challenging or outside of what my EHR can do. Does that matter?

Unlike the Meaningful Use (MU) program, the QPP allows degrees of reporting under ACI to better tailor your participation to what is available through your vendor and within your care design. Within ACI, in addition to reporting on "base measures," you can report on additional "performance measures" to increase your overall score. In general, even though you are more likely to earn a higher score if you report more measures, you could also earn a high score by reporting strong performance on a subset of measures. There are also opportunities for bonus points in the ACI category for connecting to public health or clinical data registries, and for completing an IA using CEHRT. Work with your vendor to determine which measures you can submit to help you attain your goal.

Q19. Is ACI evaluated differently for participants in an ACO?

ACO participants who are scored under and subject to MIPS will still be evaluated under the MIPS ACI category, but the weight of the ACI category will increase, and every participant in the ACO will receive a single ACO-wide

score for ACI based on the overall participation of all of the entities in the ACO. For participants in the Shared Savings Program and the Next Generation ACO Model, the ACI category will account for 30% of the MIPS performance score for the 2017 Performance Period. For MIPS APM (other than the Shared Savings Program or Next Generation) participants, the ACI category will account for 75% of the MIPS performance score for the 2017 Performance Period.

Q20. I remember that the Meaningful Use (MU) program for EHRs had hardship exemptions. Is CMS still offering those?

There are not exemptions for individual ACI measures. However, there are exclusions for participants in the following categories. The 25% weight from ACI will shift to the Quality category for participants claiming one of these exclusions.

- Insufficient Internet Connectivity – requires annual application
- Extreme and Uncontrollable Circumstances – requires annual application
- Lack of Control over the Availability of CEHRT (defined as 50% or more of the participant's outpatient encounters occur in locations where they have no control over the health IT decisions of the practice) – requires annual application
- Lack of Face-to-Face Patient Interaction – does not require an application

CMS expects to make these applications available this summer on its Quality Payment Program website on a rolling basis. The exclusion applications must be renewed each year.

Q21. I practice in a hospital and I don't really have control over how the EHR is utilized. Can I receive any sort of exemption?

Hospital-based physicians (meaning those who furnish 75% or more of their covered professional services in the sites of care identified by the Place of Service codes 21 (inpatient hospital), 22 (on-campus outpatient hospital), or 23 (emergency room)) do not need to report on ACI. The ACI component will be zeroed out and Quality will receive this additional 25% of your total MIPS score. If a hospital-based physician chooses to report on ACI, they will be scored like all other MIPS participants.

The ACI category is also automatically reweighted to 0% of the MIPS score for the following categories of eligible clinicians: physician assistants; nurse practitioners; clinical nurse specialists; certified registered nurse anesthetists; and clinicians who lack face-to-face interactions with patients. All of these MIPS eligible clinicians (including hospital-based physicians) can still optionally choose to report if they would like. If these professionals optionally report data, CMS will score their performance and weight their Advancing Care Information performance accordingly.

C. Improvement Activities (IA)

Q22. What is the IA category?

The activities within the IA category are intended to be actions your practice can take to improve patient care. For some practices, your IAs may encompass activities that you are already doing (such as 24-hour care, etc.). Physicians will report on IAs through attestation.

Q23. What are IAs?

CMS has approved more than 90 activities as IA for MIPS. Each activity is classified as high- or medium-weight and clinicians can avoid a penalty in 2017 by attesting to participation in a single IA. You may already be engaged in some of these activities. Examples of other IA activities in 2017 include annual registration in a Prescription Drug Monitoring Program and practices supporting a patient-centered action plan in the 30 days following patient discharge. CMS has provided a full list of IAs for your reference.

Q24. I see that there is an IA attestation requirement. What does that mean?

Physicians may select and attest to the completion of any of the CMS designated IAs. Remember that you are attesting to Medicare that you are completing these activities. Attesting to completing an activity without actually doing so may be deemed by the government to constitute fraud and could lead to compliance and potential enforcement risk. Participants may attest through a CMS' website or, if supported, a qualified clinical data registry, a qualified registry, or EHR. CMS will be providing additional information on attestation options at the CMS Quality Payment Program website.

Q25. I'm in a small practice and I don't see any IAs that are practical for me to do. What should I do?

CMS has stated that all participants should be able to find IAs appropriate for their practice. Participants in small (fewer than 15 clinicians), rural, or non-patient facing practices have decreased reporting requirements

(one high or two medium-weight activities). Additionally, participants in medical homes receive full credit in the IA category, and participants in APMs receive at least half credit in the IA category.

Q26. How can I earn the maximum points in this category?

CMS will evaluate this category on a maximum 40-point scale, with high-weighted activities earning 20 points and medium-weighted categories receiving 10 points. Therefore, a practice could receive a full score by attesting that, over the course of a full year, it provided a combination of high- and medium-weighted activities each for a period of 90 consecutive days. In addition, participants in an accredited patient-centered medical home receive automatic full credit in this category, while participants in APMs automatically receive at least 50% of the top score in this category.

STEP 3 – "Pick Your Pace" for MIPS Participation

2017 is a transition year to MIPS and offers you the option to "Pick Your Pace." You can elect a Minimum, Partial, or Full participation track. These options vary based on the reporting categories you must complete and how much Medicare data you must submit throughout the year.

Know your practice:

- **To help identify the MIPS track that may be right for you, consider which measures are feasible for your practice to report and whether applicable through your chosen reporting tool(s).**
- **Decide whether you will focus on avoiding a penalty or attempting to earn any bonus payment in 2019.**
- **Get to know the three different performance categories and determine which of these you are comfortable reporting during the 2017 transition period.**
- **Evaluate your capacity to submit Medicare data for 90 days or more.**
- **Determine whether you will participate as an individual or under the group practice reporting option (GPRO).**

Q28. What are the different "Pick Your Pace" tracks in 2017?

Minimum Participation. This is the easiest track and allows you to submit one Quality measure for one patient encounter and avoid a 4% penalty in 2019. You can also submit one IA or some of the elements within the ACI category to succeed in this track and avoid the penalty.

Partial Participation. This track requires MIPS reporting on more than one Quality measure, or more than one IA or the Base ACI measures plus at least one additional ACI measure. You only have to participate for 90 consecutive days in 2017. Unlike the Minimum Participation track, you can potentially receive a modest bonus if you succeed in this track. You can begin tracking your performance as late as October 2, 2017.

Full Participation. This track requires you to submit full MIPS data for at least 90 days or, ideally, a full year. And by doing so, you'll be eligible to qualify to earn a moderate upward payment adjustment, although an upward adjustment is not guaranteed.

Q29. How can I maximize my bonus in 2019?

If you have any experience with the MIPS measures, consider choosing the Full or Partial Participation track over the Minimum Participation track to get the highest possible score and payment adjustment. You must report on any measure for a minimum of 90 days, although CMS has indicated you may be more likely to achieve a higher score if you report data over a longer period. However, physicians who have already participated in the PQRS and Meaningful Use programs may do better over an entire year because there is more time to meet individual measures and achieve a positive score. There may also be an advantage to reporting on a larger number of patients over the longer period of time to avoid the potential greater negative effect of outliers when the total number of patients is small.

Q30. What if I don't pick a participation track in 2017?

If you are eligible to participate in MIPS, you will receive a 4% penalty in 2019 payments unless you report at least one Quality measure, one IA measure, or the Base ACI measures (described below). CMS permits reporting based on claims for individual physicians, so the burden of reporting can be minimal as long as you stay abreast of the timeline for participation.

Q31. What is the minimum I will need to do to avoid a penalty in 2020 and future years?

CMS has the option of adjusting these requirements on an annual basis. CMS is expected to publish the proposed requirements for the 2018 MIPS performance year in the near future.

Q32. I have heard that physicians who participate in advanced Alternative Payment Models (AAPMs) do not have to participate in MIPS, and can get 5% bonus payments instead. How do I know if I qualify?

CMS designated AAPMs meet the requirements for their participating physicians to earn 5% bonus payments and be exempt from MIPS. To qualify, physicians must be listed on the AAPM participant list on at least one of three dates: March 31, June 30, or August 31. If the AAPM organization's participants as a whole have 25% of their Medicare revenues coming through the APM for the 2017 measurement period, then all of the physicians on the participant list will receive the bonus payment in 2019.

Q33. My practice spent a lot of money to become a medical home. Are we eligible for the APM bonus and exemption from MIPS?

Theoretically, a medical home can be an AAPM in one of two ways:

1. The medical home meets general AAPM standards, including specific risk-sharing requirements for Medical Home Models; or
2. The medical home is part of a Medical Home Model expanded nationwide by the Center for Medicare & Medicaid Innovation.

For 2017, only the Comprehensive Primary Care Plus ("CPC+") model qualifies as a Medical Home Model that is eligible to earn the 5% AAPM bonus. However, other kinds of medical homes may become eligible for an AAPM bonus in the future if they adopt risk-sharing similar to CPC+, or if CMS creates an "expanded" program that includes other kinds of medical homes. Also, starting in 2019, you may count patients seen and/or reimbursement received through a **Medicaid** medical home model and private payer medical homes towards your eligibility to receive an AAPM bonus. Note that, in order to collect the 5% incentive payment, your data must be submitted through your AAPM.

Q34. If we're not eligible for the APM bonus, is there any way to use our medical home status to get a good score in MIPS?

Participants in any accredited patient-centered medical home will automatically receive full credit in the MIPS IA category. Practices participating in the CPC+ model who do not see enough patients through the model to achieve the AAPM bonus are still not required to report additional quality data and will share a single ACI score for the practice participating in CPC+. Medical homes also may be better positioned to track and report high quality, improved costs, and use of EHR.

STEP 4 – Review Your Data

CMS will provide data to help you prepare for MIPS. Many physicians have participated in the Physician Quality Reporting System (PQRS) and Value Based Modifier (VBM) programs to avoid payment penalties. CMS provides Quality and Resource Use Reports (QRURs) and feedback reports which you can obtain on the CMS website. PQRS and VBM have been rolled into MIPS, and CMS plans to provide similar reports to eligible clinicians in MIPS. These reports contain important information such as the number of physicians billing through your group, the kinds of services your group is providing, and the types of patients "attributed" to your group for purposes of these programs. Your PQRS/VBM QRURs and reports give you a snapshot of your potential scoring under MIPS, and can help you identify trouble spots or potential areas of strength for quality and cost reporting.

Know your practice:

- **Access and become familiar with your CMS-generated QRURs.**
- **Use your QRUR to begin estimating your MIPS score and identifying strengths and weaknesses of performance.**

Q35. I'm not sure how to read a QRUR report. Where can I learn how to do that?

The AMA has resources to explain how to read and understand a QRUR report. For example, the AMA has partnered with ReachMD to provide a short podcast on how to read a QRUR.

Q36. I don't know where my CMS feedback reports are. What else can I do?

All QRURs are available through the CMS Enterprise Identity Data Management (EIDM) system. You may need to request the appropriate "role" in the system to view your QRUR; the CMS help desk is available to walk you through this process.

Q37. Will I continue to receive QRURs as I participate in MIPS?

CMS will provide feedback reports covering information similar to the QRUR, and most likely distributed the same way as the QRUR, but applying the distinct MIPS rules.

Q38. I heard that my MIPS data will become public. Is that true?

Yes, all data reported through MIPS that meets the minimum data standards may be available to the public in a summarized, non-patient-identifiable manner through the Physician Compare website. These scores likely will be released in 2019. However, similar to PQRS, CMS will establish a preview period of at least 30 days prior to publication of the data, during which you can challenge inaccuracies in this data. Also, CMS will not publicly post data on measures that are new to the program—the first year a measure is incorporated into a program.

STEP 5 – Decide Whether to Report as an Individual or a Group

Once you know that you are a MIPS participant, you need to make a choice to report as a group or an individual. This choice has significant operational and revenue ramifications, so you should think carefully about which option is best for you and your practice. You can change this choice in future years.

Know your practice:

- **Consider your practice's areas of specialization and the different measures that practitioners in your group may choose to report.**
- **Understand how group reporting may affect your entire practice's MIPS score, including future bonuses or penalties.**
- **Understand your group's existing relationships with third party vendors such as qualified registries, qualified clinical data registries, or electronic health record providers that are able to assist with MIPS reporting.**

Q39. What are the benefits of reporting as an individual?

For some multi-specialty practices, it may make more sense to report individually so that different quality or IA measures may be used. Also, in instances where individual performance may otherwise be unknown, individual reporting may be beneficial to ensure that bonuses or penalties are equitably applied to individual physicians, rather than to the group as a whole.

Q40. What are the benefits of reporting as a group?

From an operational and performance-tracking standpoint, reporting as a group may be easier than reporting individually. For practices that have been reporting as a group to programs such as PQRS, the transition to MIPS may be less burdensome if the practice continues to report as a group. Keep in mind, though, that bonuses or penalties will be applied to the group as a whole, so this result may be viewed by some as unfair if some of the group's eligible providers perform poorly and others perform well.

Q41. I meet the low volume threshold, but my practice plans on reporting as a group. Do I still need to participate in MIPS?

Yes. Once a group decides to report as a group, it must report on behalf of all of the physicians and other eligible providers who bill under the same TIN.

Q42. If I bill under multiple TINs do I need to report separately for each TIN?

Yes. CMS reports data on the basis of TIN/NPI combinations. As such, your participation through each TIN will be treated as a separate record.

Q43. I am a member of a large multi-specialty group, or a large group practice owned by a hospital, and my practice has elected to report as a group. What will that mean for me?

When a practice elects to report as a group, the physicians in the group will not be able to report individually (except for services that are billed under a TIN that is different from the group's TIN – in other words, services performed for another group). That also means that the group may choose to report on measures that are not applicable to all physicians in the group. Physicians in a practice reporting as a group should make every effort to ensure that the measures selected are the ones that are most likely to result in favorable payment adjustments for the group as a whole.

STEP 6 – Identify Your Reporting Mechanism

Each MIPS component – Quality, IA, and ACI – has multiple options for reporting, with Quality offering the most options. You can use a different reporting mechanism for **each** component, but must use the same mechanism **within** a component. For example, you may use a Qualified Clinical Data Registry to report on quality, an EHR to report on ACI measures, and web-based attestation to report on IA measures. Conversely, in most cases, you may not use both an EHR and a qualified registry to report on the Quality component.

One exception is that CMS will automatically calculate an All-Cause Hospital Readmission measure for groups of 16 or more eligible clinicians using "administrative claims." If applicable, it counts towards your total quality category score, but you are still required to report on six other measures. It also will not count as your one quality measure for avoiding a penalty.

Know your practice:

- **Match up the measures you would like to report on based with your reporting mechanisms. Some quality measures are only available through certain reporting mechanisms.**
- **Assess how much your current health IT system will allow you to report.**
- **If you use an EHR, contact your EHR vendor and ask how they are meeting CMS and MIPS requirements.**

Q44. How do I report under MIPS?

MIPS components may be reported through:

- **Qualified registries.** These entities collect and submit clinical data on all types of patients, regardless of payor, to CMS on behalf of providers. Clinicians work with their registry to choose and report their selected set of measures. CMS recently released a list of approved MIPS 2017 Qualified Registries.
- **Qualified clinical data registries (QCDRs).** Similar to qualified registries, these entities are approved by CMS for the purpose of quality improvement, tracking disease and patient data and require reporting on both Medicare and non-Medicare patients. However, QCDRs are not limited to measures within the current PQRS system and often include specialty-specific measures. QCDRs may provide additional utility since they offer regular feedback reports to physicians;
- **Electronic health records (EHR)**, if the applicable vendor supports reporting; and
- **The CMS Web Interface** (for groups of 25 or more). Groups may register for the CMS Web Interface with a valid CMS Enterprise Identity Data Management (EIDM) system account.

Additionally, individuals my report the Quality component through claims and groups may report the Quality component using the CAHPS for MIPS Survey. The ACI and IA categories also may be reported by attestation from a physician or group affirming that an action or activity is occurring.

Q45. Are there differences between how groups and individuals should report the measures within MIPS components?

The following information from CMS details these differences by component based on whether you report as an individual or a group:

	Individual	Group
Quality	✓ QCDR ✓ Qualified Registry ✓ EHR ✓ Claims	✓ QCDR ✓ Qualified Registry ✓ EHR ✓ CMS Web Interface (groups of 25 or more) ✓ CAHPS for MIPS Survey
Advancing Care	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR ✓ CMS Web Interface (groups of 25 or more)
Improvement Activities	✓ Attestation via CMS' QPP Website ✓ QCDR ✓ Qualified Registry ✓ EHR	✓ Attestation via CMS' QPP Website ✓ QCDR ✓ Qualified Registry ✓ EHR ✓ CMS Web

Q46. How do I "report on a claim"?

Reporting "on a claim" means you document the applicable quality measure through a Quality Data Code (QDC) on the 1500-form (or electronic equivalent) you submit to Medicare for payment. The QDCs are non-payable Healthcare Common Procedure Coding System (HCPCS) codes composed of specified CPT Category II codes and/or G-codes that describe the clinical action

required by a measure's numerator. Clinical actions can apply to more than one condition and, therefore, can also apply to more than one measure. For MIPS, where necessary, to avoid shared CPT Category II codes, G-codes are used to distinguish clinical actions across measures. Some measures require more than one clinical action and may have more than one CPT Category II code, G-code, or a combination associated with them. Physicians should review the numerator reporting instructions for each measure carefully.

Claims-based reporting is only available for individual clinicians.

Q47. How is "reporting on a claim" different from "administrative claims"?

As described above, reporting quality measures on a claim requires use of CPT Category II or Level II G-codes on existing claims for payment. With "administrative claims," CMS calculates a measure by using claims billing data with no additional information. CMS will use administrative claims to calculate all Cost measures (in the future) and in 2017 only one Quality measure: all-cause readmissions.

Q48. What is the all-cause readmissions measure?

CMS will automatically calculate a Quality measure covering all-cause hospital readmissions for groups with 16 or more clinicians with 200 or more eligible cases in a year. An "eligible case" is a patient attributed to a group on the basis of primary care services who is admitted to a hospital during the performance year (with certain limited exceptions, such as patients who died during the admission or are suffering from cancer or primary psychiatric diseases). CMS will evaluate the number of these patients who experience an unplanned readmission to an acute care hospital within 30 days of discharge. This measure is currently part of the Value Based Modifier program, so groups may already find information about their performance on existing QRURs. Groups eligible for this measure must still report on six additional measures.

Q49. Does this mean I can avoid the 4% cut automatically without submitting data through any new system?

Although CMS will calculate certain administrative claims data on Quality measure for some physicians in large groups, this calculated data will not be considered "reporting" sufficient to avoid the MIPS penalty.

Q50. Can I report through my EHR?

Maybe, depending on your EHR. Contact your EHR vendor as soon as possible to determine their MIPS reporting and tracking capabilities and when these will be available to you. Understanding what your current EHR vendor can do will help you decide how fully you can participate in MIPS in 2017 and how you will report. This action is time-sensitive because time may be needed for training, installing IT infrastructure updates, implementing administrative or clinical workflow changes, and, potentially, engaging a new vendor – so start now.

Q51. What should I ask my vendor?

Ask your vendor the following questions:

- Is the system I am using certified by the Office of the National Coordinator for Health Information Technology (ONC)?
- The AMA's Steps Forward program has resources to help you select an EHR vendor for your practice.
- To what edition is the product I am using certified – 2014 or 2015? (In 2017, making this distinction will help you plan performance and reporting for the ACI category.)
- By what date will you (EHR vendor) be ready to help me track and report on MIPS measures?
- Does the product that I am using have dashboard functionality so I can see as I go how I'm doing on MIPS measures?

Q52. My EHR vendor says that they won't have their system "MACRA-reporting-ready" until November 2017. Is that too late, and how should I proceed?

November 2017 is too late for you to use your EHR to report your MIPS data. Unfortunately, your vendor's timeline will require you to find another reporting mechanism such as a qualified registry or a QCDR. Another option is to report through the CMS Web Interface but, to do so, you must register by June 30, 2017 and report for a group of at least 25 eligible clinicians.

Q53. Can I participate in the MIPS program without an EHR?

You can still participate in MIPS if you are not using an EHR. However, using an EHR will enable you to maximize the number of points needed to do well in your overall MIPS composite score. For example, the ACI component

of MIPS can count for 25% of your total MIPS score and participation in the ACI component requires the use of a certified EHR or (CEHRT). While the other MIPS components, such as quality and improvement activities do not expressly require the use of CEHRT, using an EHR may enable more reporting flexibility and can provide the opportunity for additional bonus points. Remember that if you a participating in MIPS as part of a group, your ACI score will contribute to the group's overall ACI and composite score.

Q54. What is the CMS Web Interface Reporting option?

Most MIPS-eligible clinicians and groups will report through a third party vendor (an EHR, QCDR, or qualified registry). However, some large groups (those with more than 25 clinicians) can choose to report through CMS's Web Interface. This is a interface is similar to the one available for groups under PQRS. If your group has not previously reported using the Group Practice Reporting Option (GPRO) Web Interface for PQRS, you will need to set up a new account through the Enterprise Identity Management (EIDM) system. If you reported through GPRO last year, there is no need to set up a new account, but you may update your existing account to change the group's number of eligible clinicians or enroll in CAHPS.

Q55. What is the CAHPS survey?

CAHPS is a survey provided to a random sample of your patients by a CMS-approved vendor. Participation in this survey is voluntary, but it serves as a high priority Quality measure and a high-weight IA measure. You must select a CMS-approved "CAHPS for MIPS" survey vendor to conduct the survey. Also, your group will only be scored on this measure if a minimum number of your patients (which differs based on the size of your practice) receive and complete the survey. If you are interested in receiving credit for this measure, you must register with CMS by June 30, 2017. More information is available here.

STEP 7 – Perform a Security Risk Analysis (if Reporting ACI Measures)

You may earn points under the ACI category for performing the Security Risk Analysis required by the Health Insurance Portability and Accountability Act (HIPAA). This kind of analysis can be time consuming to conduct and to then address all identified issues, so you should reserve time earlier in the year to complete it and respond to issues if you plan to report on ACI.

A Security Risk Analysis generally involves identifying risks and vulnerabilities to an entity's electronic protected health information and may take some time to complete. The AMA has resources on the HIPAA Security Rule & Risk Analysis to help you complete the analysis.

Know your practice:

- **Complete the Security Risk Analysis to fulfill the ACI requirements in your MIPS score.**
- **Build in time to address deficiencies that may be identified in order to ensure HIPAA compliance.**

Q56. My group previously conducted a Security Risk Analysis for HIPAA. Is this a new requirement under MACRA?

No, this requirement is the same as the longstanding requirement to perform a Security Risk Analysis under HIPAA, but is also required to receive any credit in ACI. While the HIPAA Security Rule does not specify how frequently an entity should conduct a Security Risk Analysis, the Office for Civil Rights recommends that this type of analysis be evaluated and updated annually, or as needed in response to changes in an entity's environment.

Q57. Must I do a Security Risk Analysis to get points under the ACI category?

Yes. As a base measure, performing a Security Risk Analysis is a required for successful participation in the ACI category for 2017 and subsequent years. The U.S. Department of Health & Human Services provides a toolkit to help some clinicians, such as those in smaller practices, comply with HIPAA's Security Risk Analysis requirement. The AMA also has resources on the HIPAA Security Rule & Risk Analysis to help you complete the analysis.

STEP 8 – Last Day to Begin 90-Day Reporting Period CMS

DEADLINE: OCT. 2, 2017

CMS requires 90 days of continuous data reporting to qualify for the Partial or Full Participation tracks in MIPS. Therefore, the last date to begin reporting for these tracks – and possibly earn an upward payment adjustment in 2019 – is October 2, 2017.

Know your practice:

- **Review which MIPS track or pace you selected for the 2017 transition year and when your data collection period began.**
- **Consider whether your practice can report on additional or different measures to maximize your score.**

Q58. Will I be penalized if I previously intended to "partially participate" but find I cannot do so by October?

Not necessarily. CMS has stated that you will be held harmless from any negative adjustments under the minimal (or "testing") participation track so long as you submit Quality data, base ACI measures, or one IA at any point in the year.

Q59. Are there any special considerations I should keep in mind as I consider available Quality metrics?

CMS includes "toppied out" rules that limit the payment incentives you can receive for reporting commonly used measures. As you evaluate your ability to report data, you may wish to consider whether it is possible to report additional measures unique to your practice that are not topped out.

Also, remember that new measures may be artificially capped at 3 points if CMS cannot create a baseline, and that you must meet a minimum standard to be scored on a measure (i.e., you should not report on measures associated with conditions that your practice rarely sees).

STEP 9 – Last Day of MIPS 2017 Reporting Period

CMS DEADLINE: DEC. 31, 2017

CMS is able to evaluate your performance under MIPS only if you successfully collect information about the metric you've chosen and transmit it to CMS in a reliable way. You should test that your EHR, qualified registry, or QCDR can properly receive your data, submit it to CMS, and generate usable reports. CMS has said that it will make pre-submission testing processes available for vendors to ensure that vendors are prepared for data submission on behalf of practices. CMS already uses pre-submission validation tools to assess vendors who submit PQRS data. Although, the agency will most likely adapt these tools to MIPS, it has not yet released detailed information on this process to date.

This is also your final opportunity to collect data for the year and prevent a 4% cut to your 2019 Medicare reimbursement. As a reminder, you must collect and report on only one Quality measure, one IA, or the Base ACI measures in order to qualify for minimal participation in MIPS and avoid a penalty. Physicians may choose from nearly 300 Quality measures that are searchable by priority and specialty. For example, cardiologists may elect to report on documentation of current medications in patients' medical records to fulfill the minimum reporting requirement. They may also choose from one of 90 IAs.

Know your practice:

- **Review the measures you will submit for your MIPS track and collect this data by the end of the year.**
- **Consult CMS guidance on MIPS 2017 exemptions to verify your status if you still have questions.**
- **Incorporate the results of previous test submissions, if applicable, to ensure reliable data submission.**
- **Verify that your reporting mechanism can process your data and submit it to CMS.**
- **Check in with your vendor about how pre-submission testing results.**
- **Ask your vendor to generate evaluations of your practice for the year.**
- **Use your vendor's assessment reports.**
- **Get a head start on planning for 2018.**

Q60. What can I do to reduce errors in data submission?

CMS indicated that it will allow test data submissions, if technically feasible, for individual eligible clinicians and groups to evaluate their ability to submit data during 2017. This kind of voluntary testing should help you (or your vendor) identify potential problems in your

data submission processes early enough to address any issues and, if necessary, collect additional data. CMS is expected to issue additional guidance on test data submission during 2017.

Q61. What kinds of testing apply if I am not using a third party vendor to report in 2017?

Groups that are reporting through the CMS Web Interface should become familiar with the reporting tool and make sure that they can log into the site well before the end of the year. While groups should have registered with CMS' Web Interface by June 30, 2017 in order to use this submission mechanism, you will need an Enterprise Identity Management (EIDM) system account to access the portal. CMS will require you to re-register with EIDM to access the CMS Web Interface if your account is unused for 60 days. So give yourself a buffer of time to report via the CMS Web Interface or other data reporting mechanisms.

Q62. What do I need to know about the data blocking attestation requirement?

Eligible clinicians who use certified electronic health record technology (CEHRT) to participate in the ACI category of MIPS (and MIPS APMs who are reporting ACI on behalf of their eligible clinicians), must attest they are not blocking the exchange of electronic health information. This includes: 1) not knowingly or willfully taking actions to limit EHR interoperability; 2) ensuring EHRs adhere to interoperability technical standards; and 3) responding in a timely manner to requests to access electronic health information. Take the following steps will assist physicians in their efforts to comply with these requirements:

- Communicate your requirements to limit data blocking to your health information technology (IT) vendors.
- Obtain assurances from your health IT vendors that your EHR and other health IT products were connected in accordance with your data blocking attestation requirements.
- Obtain assurances (including, if possible, contractual representations) from your health IT vendors that your EHR is implemented in a manner that will enable you to demonstrate that you have not knowingly or willfully limited the interoperability of your EHR.

Q63. How should I test my submission of claims-based reporting?

Because claims-based reporting involves the claims for payment that you are already submitting to Medicare, you will know if CMS received the quality data code on your claim based on remittance advice you will receive from your Medicare Administrative Contractor (MAC). If transmission of your Quality Data Codes (QDCs) was successful you will receive RARC code N620 and CO 246 N620.

However, this remittance advice only reflects that you successfully submitted the QDCs to CMS. It does not mean you successfully met the numerator or denominator requirements of a specific quality measure. Further, you will not be able to resubmit a claim just for the purpose of satisfying a MIPS quality measure. Therefore, it is advisable to include monitoring of QDCs in internal audit processes to identify and correct reporting errors early.

Q64. Will I receive data from CMS during 2017 to guide my data collection and reporting?

CMS should be sending your final detailed QRUR and PQRS Feedback Report reflecting your 2015 performance in September 2017. This will be the "freshest" data from CMS available to you during 2017.

CMS typically will not provide information regarding your actual performance in 2017 because most of its data collection includes a lag and is based on your experience in 2015. However, many EHR systems and vendors will provide you with some level of intra-year reporting that may provide a snapshot of how you are doing. This review also is an opportunity for you to start thinking about changes you may want to make in 2018.

Q65. Can my group change the measures on which we're reporting?

In 2017, CMS will allow you to report for periods of less than one year. This means that if you are reporting more than what is necessary for the Minimal track, you can change the measures you are reporting during the course of a year and still potentially earn a positive adjustment, as long as you report on each measure for at least 90 days. For the quality component, CMS will use the six measures on which you have the highest score to calculate your quality score.

Q66. Will my group (or I, if I report as an individual) be penalized for reporting more than six Quality measures?

No. CMS will calculate your score based on the six measures on which your group (or, if reporting individually, you) achieved the highest scores (so long

as you report a minimum of 20 cases for each measure). You also can wait until the end of the year to decide which measures to submit (so long as you have collected data applicable to those measures). If the overall measures you submit include additional outcome or high priority measures, you can receive bonus points.

Q67. What other kinds of program information can I expect from CMS during this period?

CMS has stated it intends to provide guidance on the low-volume threshold and other information about your responsibilities under MIPS for 2018 by December 2017.

STEP 10 – Submit 2017 MIPS Data

CMS will accept your data in a reporting period between January 2 and March 31, 2018; however, each reporting mechanism has its own parameters and deadlines for data submission.

Know your practice:

- **Keep in mind some reporting mechanisms may require you to begin submission earlier than March 31, 2018.**
- **Know your right to review if you believe that CMS has made an error in your MIPS assessment.**

Q68. Can I submit all my group practice's data on March 31, 2018?

Most likely not. Some qualified registries, QCDRs, and EHRs may be able to report on a single day, although they will typically have internal deadlines several weeks before this date. However, CMS will only allow submission through the CMS Web Interface during an 8-week period between January 2, 2018 and March 31, 2018. This is consistent with the process currently used for PQRS, and CMS will publish the exact reporting period in future guidance. Although CMS has stated it would like to allow "test" reporting earlier in the year, it has not released information about this kind of test reporting yet.

Q69. What do I do if I believe CMS has made a mistake in assessing my data?

After CMS has calculated a performance score for the individual or group, the group may request a "targeted review" of their data and the calculation process. A group may request a targeted review starting within 60 days of the date CMS provides a feedback report to the practice and continuing until September 30, 2018 (or later if specified by CMS). CMS has stated it will provide additional information on this process in future guidance.

Q70. What is the submission deadline for each reporting method?

Reporting mechanisms, such as EHR vendors, QCDRs, and Qualified Registries, must submit MIPS 2017 performance data to CMS before March 31, 2018. Groups reporting through the Web Interface must submit data during an 8-week period specified by CMS between January 1, 2018 and March 31, 2018 (CMS will publish the exact time frame on its website closer to the submission deadline). Keep in mind that each vendor may have its own due date for receipt of data from MIPS eligible clinicians and groups; you should check with your chosen vendor for such deadlines. Additionally, note that claims based reporting must be completed and documented at the time you submit your claim for payment to Medicare.

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