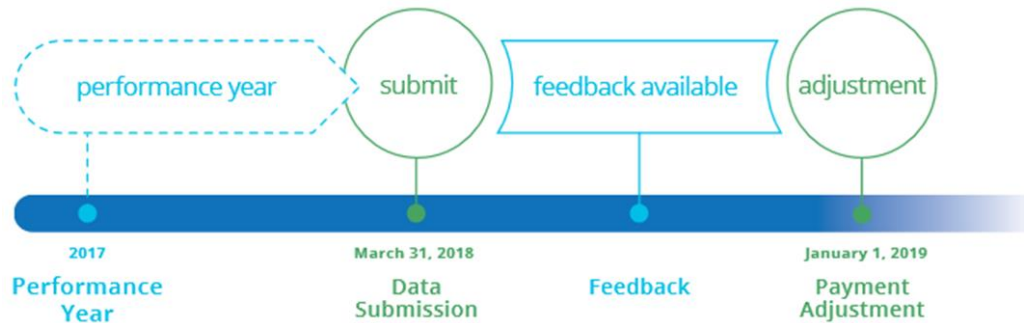


Merit-based Incentive Payment System (MIPS) for Medicare Part B Providers

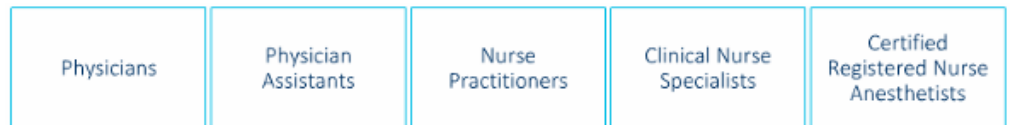
About MIPS:

The **Merit-based Incentive Payment System** or **MIPS**, is a program that replaces past **Centers for Medicare and Medicaid Services (CMS)** programs and combines them under one program. Eligible clinicians who are not participating in an **Advanced Alternative Payment Model (APM)** will be required to report data to CMS for MIPS in 2017. The diagram above details the timeline for 2017 MIPS reporting.



In MIPS, you earn a payment adjustment based on evidence-based and practice-specific quality data. Based on your participation in 2017, you will see a positive, neutral, or negative adjustment of up to 4% to your Medicare payments for covered professional services that will be applied. This adjustment percentage grows to a potential of 9% in 2022 and beyond.

Eligible clinicians:

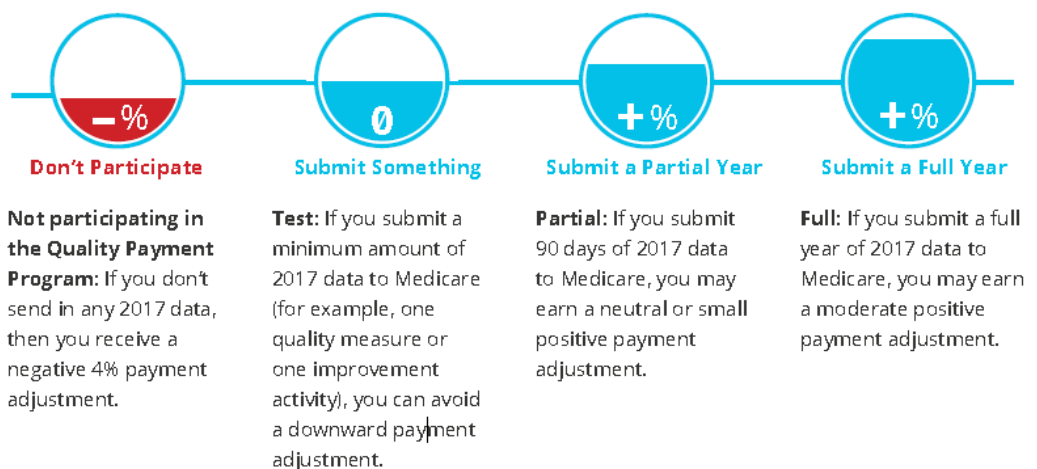


Clinicians who bill Medicare, had greater than 100 Medicare Part B patients and exceeded \$30,000 in Medicare Part B allowed charges between September 1, 2015 and August 31, 2016, and fall into one of the categories in the diagram above will be considered eligible for participating in MIPS in 2017. CMS defines a “physician” as a “doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, doctor of optometry, or a doctor of chiropractic.”

Clinicians who are eligible for MIPS will be notified by CMS regarding their eligibility. If you are not eligible to participate in MIPS in 2017, your practice still has the option and is encouraged to submit information to CMS and receive feedback on your performance. Clinicians outside of those listed above are expected to be eligible for MIPS in future years.


Pick your pace:

During the 2017 calendar year, eligible clinicians participating in MIPS can participate by choosing one of three reporting options. Eligible clinicians who do not participate will incur a negative payment adjustment in 2019.



Program components:

The MIPS program replaces prior CMS sponsored programs and combines them into one program with four components. The diagram to the right shows the CMS programs are being replaced by components of MIPS.

 Quality	 Improvement Activities	 Advancing Care Information	 Cost
Replaces PQRS.	New category.	Replaces the Medicare EHR Incentive Program also known as Meaningful Use.	Replaces the Value-Based Modifier.

The Improvement Activities program component is a new category that does not align with past CMS reporting requirements. Participating in the **Transforming Clinical Practice Initiative (TCPI)** alone meets the Improvement Activity requirement for provider groups of 15 or fewer clinicians (high weighted activity).

Reporting options:

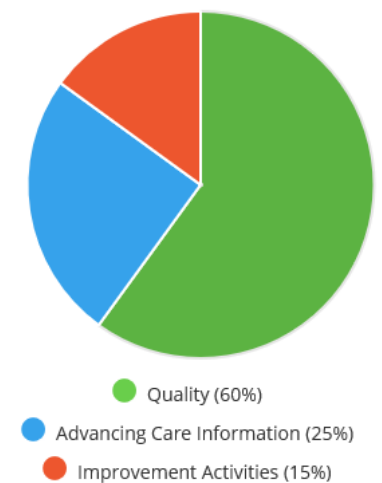
During the 2017 calendar year, an eligible practice will be responsible for submitting data for three of the four program components (Quality, Improvement Activities, and Advancing Care Information). The diagram to the right shows how each component of the program is weighted in your overall practice score. Cost data does not need to be submitted and will be reviewed by CMS via claims.

Your practice can choose to report individually or as a group. An individual is defined by CMS as a single NPI tied to a single **Tax Identification Number (TIN)**. To report as a group, all providers must fall under the same TIN. When submitting as a group, payment adjustment is determined based on the group's performance. Please note that if your practice submits as a group, all providers must submit performance across the same set of quality measures.

Data submission options:

- Individual reporting – certified electronic health record, registry, claims, or a qualified clinical data registry
- Group reporting - CMS web interface, certified electronic health record, registry, or a qualified clinical data registry

2017 MIPS Performance



Preparing for MIPS Checklist

What can my practice do today?

- Confirm eligibility and determine how MIPS will impact your practice – <https://apps.ama-assn.org/pme/#/>
- Visit the QPP website - <https://qpp.cms.gov/> and review the “Explore Measures” section to determine what 6 measures your practice will report. At least one measure should be an outcome measure. If one does not exist for your specialty, choose at least one high priority measure. Note that all measures must fall within the same data submission category.
- Check that your electronic health record vendor is certified under the 2014 or 2015 standards by the Office of the National Coordinator for Health Information Technology by visiting this website – <https://chpl.healthit.gov/#/search>.
- Review the pick your pace reporting options and choose what option your practice will take in 2017 reporting.
- Review your practice's cost performance via the 2015 Quality and Resource Use Report (QRUR). This report is available to all providers nationally, and can be accessed on behalf of a group or solo practitioner at <https://portal.cms.gov>.

The content provided in this document is advisory in nature and makes no assurances of any kind with respect to opinions or assessments that have been, or might be determined by CMS and does not constitute an endorsement by CMS. Every reasonable effort has been made to present current and accurate information, however, the Southern New England Practice Transformation Network makes no guarantees of any kind. Additional guidance can be found at qpp.cms.gov. Last updated 2/21/2017