1. **What is MACRA?**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is bipartisan legislation signed into law on April 16, 2015. MACRA provides a framework for clinicians to successfully take part in the Quality Payment Program (QPP) that rewards value and outcomes in one of two ways:

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

Although there are two separate pathways within the QPP (MIPS and Advanced APMs), both contribute toward the goal of seamless integration of the QPP into clinical practice workflows. The Centers for Medicare & Medicaid Services (CMS) began implementing the QPP through rulemaking for calendar year 2017, and on November 2, 2017 released a 2018 final rule that makes updates to the QPP under the MACRA, including MIPS and Advanced APM. The provisions of the final rule with comment period became effective on January 1, 2018. Performance Year 2 includes the 2018 performance period and the 2020 MIPS payment year.

2. **What is the Merit-Based Incentive Payment System (MIPS)?**

Merit-Based Incentive Payment System (MIPS) is the name of a program that will determine Medicare payment adjustments. MIPS is one of two paths to payment under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program (QPP). MIPS consolidates the following three quality incentive payment programs into one program:

- The Physician Quality Reporting System (PQRS) that requires eligible professionals to report on clinical quality measures;
- The Medicare Electronic Health Records (EHR) Incentive Program, otherwise known as “Meaningful Use,” which provides incentive payments for certain health care providers to use EHR technology to improve patient care;
- The Value-based Payment Modifier (VBM), which uses claims and PQRS data to adjust Medicare payments based on quality and cost of care.

The primary way that MIPS measures quality of care is through a set of clinical quality measures (CQMs) from which MIPS eligible clinicians can select. The CQMs are evidence-based, and the majority are created or supported by clinicians.

The first performance period (Performance Year 2017) closed December 31, 2017, and 2017 data were due to be submitted by March 31, 2018. The first payment adjustments based on performance will go into effect on January 1, 2019. CMS anticipates that more than 90 percent of eligible clinicians who bill Medicare Part B are subject to MIPS in 2018.

---

1 These FAQs are based on information provided in the 2018 MACRA final rule and are accurate as of June 18, 2018.
3. **Is MIPS a pay-for-reporting system, like the Physician Quality Reporting System (PQRS)?**
   No. Unlike PQRS, MIPS is not a pay-for-reporting program, and will not have a “satisfactory reporting” requirement. The data you submit for each quality measure will be compared to benchmarks in order to determine your Quality score. The baseline period for deriving benchmarks will be two years prior to the performance year, which will enable CMS to publish measure benchmarks prior to the start of the relevant performance year.

4. **Who is eligible to participate in MIPS?**
   There is *no change* from Year 1 in the types of clinicians eligible to participate in Year 2 (2018). MIPS eligible clinicians include:
   - Physicians (including psychiatrists)
   - Physician Assistants
   - Nurse Practitioners
   - Clinical Nurse Specialists
   - Certified Registered Nurse Anesthetists

   There were *no changes* made to basic exemption criteria. In Year 2 (2018), MIPS does **NOT** apply to:
   - Clinicians who enroll in Medicare for the first time in 2018
   - Clinicians who participate in an Advanced APM and are either a Qualifying APM Participant (QP) or Partial QP
   - Clinicians who are not in a MIPS-eligible specialty
   - Clinical psychologists and licensed clinical social workers (although they may be added to the eligible list in 2019)
There was a change in the low-volume threshold for Year 2 (2018). For Year 2, MIPS eligible clinicians billing more than $90,000 a year in Medicare Part B allowed charges AND providing care for more than 200 Medicare patients a year will be included.

**No Change in Basic Exemption Criteria**

5. **What is the low-volume threshold for Year 2 (2018)?**

The low-volume threshold is a way to exclude eligible clinicians from MIPS based on the volume of services they deliver to Medicare beneficiaries. The original MACRA final rule from Year 1 set the low-volume threshold at either $30,000 of Part B allowable charges OR 100 Medicare beneficiaries. In Year 2, in order for a clinician or a group to be eligible to participate in MIPS relative to the low-volume threshold, a clinician or group would need to EXCEED the low-volume threshold (both components of the low-volume threshold – bill $90,000 AND see 200 Medicare Part B patients). If you only bill $90,000 and see less than 200 patients, or if you bill less than $90,000 and see 200 patients, you cannot participate in MIPS. Both $ and # of patients must be met in order to participate and receive adjustments.

If a practice chooses to report as a group, then the low-volume threshold would be applied at the group level. If the clinicians at the practice decide to participate as individuals, the low-volume threshold would be applied at the individual clinician level.

6. **Since MIPS may not apply to psychologists and social workers until 2019, does that mean they will have to participate in the Physician Quality Reporting System (PQRS) in 2018?**

No, they will not have to participate in PQRS. PQRS, the Value-Based Modifier and Medicare’s Meaningful Use program are officially “sun setting” and do not apply to any clinician as of January 1, 2017.
7. Our clinic has a mix of psychologists, social workers, nurse practitioners, and psychiatrists. Since half of them are required to participate in MIPS in 2018, should the social workers and psychologists participate as well?
LCSWs, clinical psychologists and other non-MIPS eligible clinicians can elect to participate in MIPS in 2018. The proposed rule states that if non-MIPS eligible individual clinicians and groups elect to participate, CMS would calculate administrative claims resource use measures and quality measures, if data are available.

8. How do I report to MIPS as an individual clinician?
If you send MIPS data in as an individual, your payment adjustment will be based on your performance. An individual is defined as a single National Provider Identifier (NPI) tied to a single Tax Identification Number. You’ll send your individual data for each of the MIPS categories through an electronic health record, registry, or a qualified clinical data registry. You may also send in quality data through your routine Medicare claims process.

9. How do I report to MIPS as part of a group?
If you send your MIPS data with a group, the group will get one payment adjustment based on the group’s performance. A group is defined as a set of clinicians (identified by their NPIs) sharing a common Tax Identification Number, no matter the specialty or practice site. Your group will send in group-level data for each of the MIPS categories through the CMS web interface or an electronic health record, registry, or a qualified clinical data registry.

Beginning in 2018, CMS added a new participation option: Virtual Groups. A Virtual Group is a combination of two 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. A solo practitioner or group can only participate in one virtual group during a performance period. To be eligible to join or form a virtual group, you would need to be a:
- Solo practitioner who exceeds the low-volume threshold individually, and is not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS.
- Group that has 10 or fewer eligible clinicians and exceeds the low-volume threshold at the group level.

Virtual groups participate in MIPS across all four performance categories, and are subject to the same measure and performance category requirements as other groups reporting under MIPS. Virtual groups can submit data the same ways groups can. Each virtual group would aggregate its data across its TINs for each performance category and be assessed and scored at the virtual group level. CMS’s Virtual Groups Toolkit contains more information.
10. What is the election process for virtual groups?
Solo practitioners and groups who want to form a Virtual Group must go through the two-stage election process:

- **Stage 1 (optional):** Solo practitioners or groups with 10 or fewer eligible clinicians can choose to contact their local QPP Technical Assistance organization to see if they are eligible to join or form a virtual group.
- **Stage 2:** For groups that don’t participate in Stage 1 and don’t ask for an eligibility determination, CMS will see if they are eligible to be in a virtual group during Stage 2 of the election process.

Each virtual group has to have a written formal agreement between each of the virtual group members before election; name an official representative; must have emailed the group’s election by December 31, 2017; included at least the information about each TIN and NPI associated with the virtual group and the virtual group representative’s contact information.

Election must occur prior to the beginning of the performance period and cannot be changed once the performance period starts. Election period for the 2018 MIPS performance period was October 11 through December 31, 2017. CMS’s Virtual Groups Toolkit contains more information.

11. What is the advantage of reporting as a virtual group?
Solo practitioner or groups with 10 or fewer eligible clinicians (small practices) have the ability to determine the most appropriate means for participating in MIPS, whether it be as individuals, as a group, or as part of a virtual group. The formation of virtual groups provides for a comprehensive measurement of performance, shared responsibility, and an opportunity to effectively and efficiently coordinate resources to achieve requirements under each performance category. A small practice may elect to join a virtual group in order to potentially increase their performance under MIPS or elect to participate in MIPS as a group and take advantage of other flexibilities and benefits afforded to small practices.

12. How do I know if my EHR is certified?
Check that your electronic health record is certified by the Office of the National Coordinator for Health Information Technology. CMS has included a link to this office on its Quality Payment Program website. If your electronic health record is certified, it should be ready to capture information for the MIPS advancing care information category and certain measures for the quality category.

13. How does MIPS measure performance?
In Year 2 (2018), MIPS eligible clinicians can earn a payment adjustment based on evidence-based and practice-specific quality data. Payments to providers are still based on the Medicare Part B Physician Fee Schedule (PFS) but those payments can be adjusted either up or down depending on their Final Score, which is made up of the following four performance categories:

- **Quality** (50 points)
- Clinical Practice Improvement Activities, referred to as “Improvement Activities” (15 points)
- Meaningful use of CEHRT, referred to as “Advancing Care Information” (25 points)
- Resource use, referred to as “Cost” (10 points)
14. How is the MIPS Year 2 (2018) payment adjustment calculated?

Each of the four categories listed above are weighted and collectively form a final score on a scale from 0-100. CMS will compare the final score to a performance threshold and determine whether a clinician or group will receive a positive, neutral, or negative payment adjustment. In 2017, the performance threshold was only 3/100 points, which enabled the majority of participating clinicians to receive a neutral or positive payment adjustment in 2019. In Year 2 (2018), CMS raised the performance threshold to 15/100 points. The payment adjustment for 2018 is set at +/- 5%.

### Transition Year 1 (2017) Final

- 3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%

### Year 2 (2018) Final

- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

**How can I achieve 15 points?**

- Report all required Improvement Activities.
- Meet the Advancing Care Information base score and submit 1 Quality measure that meets data completeness.
- Meet the Advancing Care Information base score, by reporting the 5 base measures, and submit one medium-weighted Improvement Activity.
- Submit 6 Quality measures that meet data completeness criteria.

---

<table>
<thead>
<tr>
<th>Final Score 2017</th>
<th>Payment Adjustment 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥70 points</td>
<td>Positive adjustment</td>
</tr>
<tr>
<td></td>
<td>Eligible for exceptional performance bonus—minimum of additional 0.5%</td>
</tr>
<tr>
<td>4-69 points</td>
<td>Positive adjustment</td>
</tr>
<tr>
<td></td>
<td>Not eligible for exceptional performance bonus</td>
</tr>
<tr>
<td>3 points</td>
<td>Neutral payment adjustment</td>
</tr>
<tr>
<td>0 points</td>
<td>Negative payment adjustment of -4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Final Score 2018</th>
<th>Change</th>
<th>Payment Adjustment 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥70 points</td>
<td>N</td>
<td>Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eligible for exceptional performance bonus—minimum of additional 0.5%</td>
</tr>
<tr>
<td>15.01-69.99 points</td>
<td>Y</td>
<td>Positive adjustment greater than 0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not eligible for exceptional performance bonus</td>
</tr>
<tr>
<td>15 points</td>
<td>Y</td>
<td>Neutral payment adjustment</td>
</tr>
<tr>
<td>3.76-14.99 points</td>
<td>Y</td>
<td>Negative payment adjustment greater than -5% and less than 0%</td>
</tr>
<tr>
<td>0-3.75 points</td>
<td>Y</td>
<td>Negative payment adjustment of -5%</td>
</tr>
</tbody>
</table>
15. What do I have to do to report in each MIPS performance category?

In Year 2 (2018), CMS will factor in quality (50%), improvement activities (15%), advancing care information (25%), and cost (10%) to determine MIPS eligible clinicians’ final score.

| Quality | For 2018, there are 6 topped out measures that be will scored with a maximum of 7-points for a 12-month performance period (instead of 90 days in 2017):

- Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin. (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)

CMS proposes an increase to the data completeness threshold to 60% instead of 50%. Measures that do not meet data completeness criteria will get 1 point instead of 3 points, except that small practices will continue to get 3 points. |

| Advancing Care Information | Choose to submit up to 9 measures for a minimum of 90 days for additional credit.

Awarded a base score of 50% if you submit the numerator (of at least “1”) and denominator, or “yes” for the yes/no measure, for each required measure. If the base score isn’t met, you will get a zero for the Advancing Care Information category.

For the performance score, you or your group may earn 10% in the performance score for reporting to any single public health agency or clinical data registry. A 5% bonus score is available for submitting to an additional public health agency or clinical data registry not reported under the performance score.

Additional activities are eligible for a 10% Advancing Care Information bonus if you use CEHRT to complete at least one of the specified Improvement Activities. A 10% bonus score will be applied for using the 2015 Edition exclusively. |

| Improvement Activities | • **Most participants**: Attest that you completed up to four improvement activities for a minimum of 90 days.
- **Groups with fewer than 15 participants or those in a rural or health professional shortage area**: Attest that you completed up to two activities (or 1 high-weighted activity) for a minimum of 90 days to reach the **highest score**.
For group participation, only 1 MIPS eligible clinician in a TIN has to perform the Improvement Activity for the TIN to get credit. |
• Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit.

Must submit data on activities in one of the following manners:
• Via qualified registries, EHR submission mechanisms, QCDR, CMS Web Interface, or attestation; and
• For activities that are performed for at least a continuous 90 days during the performance period, clinicians must submit a YES response for activities within the Improvement Activities inventory.

| Cost | CMS will calculate cost measure performance; no action is required from clinicians for Year 2 (2018). CMS is including the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures to calculate your Cost performance category score for the 2018 MIPS performance period. These two measures carried over from the Value Modifier program and are currently being used to provide feedback for the MIPS transition year. |

16. What behavioral health-related MIPS quality measures are available in 2018?

CMS’s Quality Payment Program (QPP) website enables you to browse the measures and select the ones that you feel best align with your practice in a ‘shopping cart’ for further review. This tool also allows you to search quality measures by submission method, and according to whether it is a “high priority” measure or appears on a specialty measure list.

CMS significantly expanded the list of quality measures available under the behavioral health specialty measure set in the final rule. (The 2017 proposed rule contained only 10 behavioral health-related measures, the majority of which pertained to dementia). In 2018, clinicians may report measures from the Mental/Behavioral Health Specialty Set to fulfill this requirement (information about 2018 measures can be found here: 2018 Resources), but MIPS provides a very limited number of behavioral health-related quality measures. If a clinician/group can only report on fewer than six measures, CMS may reduce the weight of the Quality category and reassign the missing weight proportionally to other performance categories.

17. What behavioral health-related MIPS improvement measures are available in 2018?

Clinicians can review 2018 behavioral-health related MIPS improvement activity measures here.

To earn full credit in this category, participants must submit one of the following combinations of activities (each activity must be performed for 90 days or more during 2018):
• 2 high-weighted activities
• 1 high-weighted activity and 2 medium-weighted activities
• At least 4 medium-weighted activities

You will receive double points for each high- or medium-weighted activities you submit if you are an Individual Clinician, Group, or Virtual Group who holds any of these special statuses:
- Small practice
- Non-patient facing
- Rural
- Health Professional Shortage Area (HPSA)

If you are a participant in a certified patient-centered medical home or comparable specialty practice, you will earn the maximum Improvement Activity category score by attesting to this during the submission period. Some Improvement Activities are marked as “CEHRT-Eligible,” meaning the activity is eligible for a 10% bonus points award in the promoting interoperability performance category.

18. **What Advancing Care Information measures are available in 2018?**

There are 2 measure sets for submitting data:
- Promoting Interoperability Objectives and Measures
- Promoting Interoperability Transition Objectives and Measures.

You can view Promoting Interoperability Measures [here](#).

The measure set you choose is based on your CEHRT edition. If your CEHRT is certified to the 2014 Edition, you must use the Promoting Interoperability Transition Objectives and Measures set. Otherwise, you may use either set, or any combination of the two sets.

For Performance Year 2018, Certified EHR Technology (CEHRT) is required for participation in this performance category. If participants do not have CEHRT they may be eligible for a hardship exception. Participants must submit collected data for 4 or 5 Base Score measures (depending on the CEHRT Edition) for 90 days or more during 2018. In addition to submitting the Base Score measures, participants must attest to two statements when submitting: “Prevention of Information Blocking Attestation,” and “ONC Direct Review Attestation.”
19. When do MIPS data need to be reported for the 2018 performance year?
The provisions of the final rule with comment period and interim final rule with comment period become effective on January 1, 2018. Performance Year 2 includes the 2018 performance period (January 1, 2018 through December 31, 2018) and the 2020 MIPS payment year. For the Year 2 MIPS performance period, the data submission deadline is March 31, 2019.

20. Are there any special MIPS provisions or exemptions for small or solo behavioral health practices?
Yes. The final rule includes the following provisions for small, rural, and underserved practices:
- Excluding individual MIPS eligible clinicians or groups with less than or equal to $90,000 in Part B allowed charges or less than or equal to 200 Part B beneficiaries
- Adding 5 bonus points to the final scores of small practices
- 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 Advancing Care Information performance category for small practices

MACRA also provides $20 million each year for five years to fund training and education for Medicare clinicians in individual or small group practices of 15 clinicians or fewer and those working in underserved areas.
21. Does MIPS affect...
- Medicare Advantage or managed care?
- Medicaid reporting and reimbursement?
- Medicare reimbursement for Rural Health Clinics or FQHCs?
- Medicare reimbursement for hospitals or facilities?

   No. MIPS only applies to clinicians who bill Medicare Part B using the physician fee schedule, and does NOT apply to hospitals or facilities.

22. What is the definition of “complex patients” as it pertains to receiving the bonus payment?
CMS will award providers between one and five bonus points based on their treatment of Complex Patients. The determination of a Complex Patient is based on the dual eligible ratio and the Hierarchical Conditions Category (HCC) risk score. The overall goal when considering a bonus for complex patients is two-fold: (1) to protect access to care for complex patients and provide them with excellent care; and (2) to avoid placing MIPS eligible clinicians who care for complex patients at a potential disadvantage while we review the completed studies and research to address the underlying issues.

CMS uses the term “patient complexity” to take into account a multitude of factors that describe and have an impact on patient health outcomes; such factors include the health status and medical conditions of patients, as well as social risk factors. CMS believes that as the number and intensity of these factors increase for a single patient, the patient may require more services, more clinician focus, and more resources in order to achieve health outcomes that are similar to those who have fewer factors. In developing the policy for the complex patient bonus, CMS assessed whether there was a MIPS performance discrepancy by patient complexity using two well-established indicators in the Medicare program. The proposal was intended to address any discrepancy, without masking performance. Because this bonus is intended to be a short-term strategy, CMS proposed the bonus only for the 2018 MIPS performance period (2020 MIPS payment year) and noted that it will be reassessed annually.
23. What are the Quality Payment Program 2018/Year 2 MIPS Highlights?

In Year 2 (2018) of the Quality Payment Program (QPP), CMS is keeping many of the transition year policies and making some minor changes including:

- Raising the performance threshold to 15 points (from 3 points in the transition year)
- Allowing the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in Year 2, and giving you a bonus for using only 2015 CEHRT
- Giving up to 5 bonus points on your final score for treatment of complex patients
- Automatically weighting the Quality, Advancing Care Information, and Improvement Activities performance categories at 0% of the final score for clinicians impacted by hurricanes Irma, Harvey and Maria and other natural disasters
- Adding 5 bonus points to the final scores of small practices

More options for Small Practices

Realizing the challenges that small practices face in participating in the QPP, CMS offers tailored flexibilities for groups of 15 or fewer clinicians including:

- Excluding individual MIPS eligible clinicians or groups with less than or equal to $90,000 in Part B allowed charges or less than or equal to 200 Part B beneficiaries
- Adding 5 bonus points to the final scores of small practices
- 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 Advancing Care Information performance category for small practices

Gradual Implementation

The following policies were finalized to ensure that clinicians are ready for full implementation in 2019/Year 3:

- Weighting the MIPS Cost performance category to 10% of your total MIPS final score. CMS is including the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures to calculate your Cost performance category score for the 2018 MIPS performance period. These two measures carried over from the Value Modifier program and are currently being used to provide feedback for the MIPS transition year. CMS will calculate cost measure performance; no action 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 QPP performance information on Physician Compare

Extreme and Uncontrollable Circumstances

Numerous clinicians have been affected by Hurricanes Harvey, Irma, and Maria during the 2017 MIPS performance period. CMS addresses extreme and uncontrollable circumstances for both the transition year and the 2018 MIPS performance period in this final rule with comment:

- For the transition year (2017), if a MIPS eligible clinician’s CEHRT was unavailable as a result of extreme and uncontrollable circumstances (e.g., a hurricane, natural disaster,
or public health emergency), the clinician could submit a hardship exception application to be considered for reweighting of the Advancing Care Information performance category.

- This final rule with comment period extends this reweighting policy for the three other performance categories (Quality, Cost, and Improvement Activities) starting with the 2018 MIPS performance period. This hardship exception application deadline is December 31, 2018.
- Because of policies relating to reweighting the Quality, Cost, and Improvement Activities performance categories are not effective until 2018, CMS is issuing an interim final rule for automatic extreme and uncontrollable circumstances where clinicians can be exempt from these categories in the transition year (2017) without submitting a hardship exception application (note that cost has a 0% weight in the transition year).

Clinicians in affected areas that do not submit data will not have a negative adjustment. Clinicians that do submit data will be scored on their submitted data. This allows them to be rewarded for their performance in MIPS. Because MIPS is a composite, clinicians have to submit data on two or more performance categories to get a positive payment adjustment.
24. What are the differences between Year 1 (2017) and Year 2 (2018) of the Quality Payment Program for MIPS?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-volume threshold</td>
<td>You’re excluded if you or your group has ≤ $30,000 in Part B allowed charges OR ≤ 100 Part B beneficiaries.</td>
<td>You’re excluded if you or your group has ≤ $90,000 in Part B allowed charges OR ≤ 200 Part B beneficiaries.</td>
</tr>
<tr>
<td>Non-patient facing</td>
<td>Individual - If you have ≤ 100 patient facing encounters</td>
<td>No change for Year 2 to Individual and Group policy</td>
</tr>
<tr>
<td></td>
<td>Groups - If your group has &gt;75% NPIs billing under your group’s TIN during a performance period considered as non-patient facing.</td>
<td>Virtual Groups have same definition as groups. Virtual Groups that have &gt;75% NPIs billing under the Virtual Group’s TINs during a performance period who are non-patient facing.</td>
</tr>
<tr>
<td>Ways to submit</td>
<td>You use only one submission mechanism per performance category.</td>
<td>No change for Year 2.</td>
</tr>
<tr>
<td>Virtual Groups</td>
<td>Not an option in Year 1</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Solo practitioners and small groups may only participate in a Virtual Group if you exceed the low-volume threshold.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The MIPS payment adjustments will only apply to the MIPS eligible clinicians in a Virtual Group.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If the 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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Components are finalized for a formal written agreement between each member of the Virtual Group.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If certain members of a Virtual Group are in a MIPS APM, we’ll apply the APM Special Scoring Standard instead of the Virtual Group score.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Generally, policies that apply to groups would apply to Virtual Groups. Differences include:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Definition of non-patient facing MIPS eligible clinician</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Small practice status</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Rural area and Health Professional Shortage Area designations</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------------------------------------------------</td>
<td>----------------------------------------------------------------</td>
</tr>
<tr>
<td>Quality Performance Measure</td>
<td>Weight to final score:</td>
<td>Weight to final score:</td>
</tr>
<tr>
<td></td>
<td>• 60% in 2019 payment year</td>
<td>• Finalized at 50% in 2020 payment year</td>
</tr>
<tr>
<td></td>
<td>• 50% in 2020 payment year</td>
<td>• 30% in 2021 payment year and beyond</td>
</tr>
<tr>
<td></td>
<td>• 30% in 2021 payment year and beyond</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data completeness:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 50% for submission mechanisms except for Web Interface and CAHPS</td>
<td>• 60% for submission mechanisms except for Web Interface and CAHPS</td>
</tr>
<tr>
<td></td>
<td>• Measures that don’t meet the data completeness criteria earn 3 points</td>
<td>• Measures that don’t meet the data completeness criteria will earn 1 point, except for a measure submitted by a small practice, which will earn 3 points.</td>
</tr>
<tr>
<td></td>
<td>Scoring:</td>
<td>Scoring:</td>
</tr>
<tr>
<td></td>
<td>• 3-point floor for measures scored against a benchmark</td>
<td>• No change for Year 2.</td>
</tr>
<tr>
<td></td>
<td>• 3 points for measures that don’t have a benchmark or don’t meet case minimum requirements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Bonus for additional high priority measures up to 10% of denominator for performance category</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Bonus for end-to-end electronic reporting up to 10% of denominator for performance category</td>
<td></td>
</tr>
<tr>
<td>Quality/ topped out quality measures</td>
<td>Not applicable for 2017.</td>
<td>• Topped-out measures will be removed and scored on 4 year phasing out timeline.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Topped out measures with measure benchmarks that have been topped out for at least 2 consecutive years will earn up to 7 points.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The 7-point scoring policy for 6 topped out measures identified for the 2018 performance period is finalized. These 6 topped out measures include the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin. (Quality Measure ID: 21)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Melanoma: Overutilization of Imaging Studies in Melanoma. (Quality Measure ID: 224)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients). (Quality Measure ID: 23)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Image Confirmation of Successful Excision of Image-Localized Breast Lesion. (Quality Measure ID: 262)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description (Quality Measure ID: 359)</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy (Quality Measure ID: 52)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Topped out policies do not apply to CMS Web Interface measures, and CMS will monitor for differences with other submission options.</td>
</tr>
<tr>
<td>Cost Performance Measure</td>
<td>Weight to final score: • 0% in 2019 payment year</td>
<td>Weight to final score: • Finalized at 10% in 2020 payment year • 30% in 2021 MIPS payment year and beyond</td>
</tr>
<tr>
<td></td>
<td>Measures: • Includes the Medicare Spending per Beneficiary (MSPB), total per capita cost measures, and 10 episode-based cost measures.</td>
<td>Measures: • Includes the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures for the Cost performance category for the 2018 MIPS performance period. • For the 2018 MIPS performance period, CMS won’t use the 10 episode-based measures adopted for the 2017 MIPS performance period. • CMS is developing new episode-based measures with stakeholder input and soliciting feedback on some of these measures fall 2018. • CMS expects to propose new cost measures in future rulemaking and solicit feedback on episode-based measures before they are included in MIPS.</td>
</tr>
<tr>
<td></td>
<td>Reporting/Scoring: • Calculate individual MIPS eligible clinician’s and group’s Cost performance using administrative claims data 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. • 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 2 measures. • If only 1 measure can be scored, that score will be the performance category score.</td>
<td>Reporting/Scoring: • <strong>No change for Year 2.</strong></td>
</tr>
<tr>
<td>Improvement scoring for Quality &amp; Cost</td>
<td>Not applicable for 2017.</td>
<td>For Quality: • Measure improvement at the performance category level. • Up to 10 percentage points available in the Quality performance category.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For Cost: • Improvement scoring based on statistically significant changes at the measure level. • Up to 1 percentage point available in the Cost performance category.</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>For Quality and Cost:</td>
<td>• If the improvement score can’t be calculated because there is not sufficient data, CMS will assign an improvement score of 0 percentage points.</td>
<td>• If the improvement score can’t be calculated because there is not sufficient data, CMS will assign an improvement score of 0 percentage points.</td>
</tr>
<tr>
<td></td>
<td>• CMS will figure an improvement score only when there’s sufficient data to measure improvement (e.g., MIPS eligible clinician uses the same identifier in 2 consecutive performance periods and is scored on the same cost measure(s) for 2 consecutive performance periods).</td>
<td>• CMS will figure an improvement score only when there’s sufficient data to measure improvement (e.g., MIPS eligible clinician uses the same identifier in 2 consecutive performance periods and is scored on the same cost measure(s) for 2 consecutive performance periods).</td>
</tr>
<tr>
<td>Improvement Activities Performance Measure</td>
<td>Weight to final score: 15% and it is measured based on a selection of different medium and high-weighted activities.</td>
<td>Weight to final score:</td>
</tr>
<tr>
<td></td>
<td>Number of activities:</td>
<td>• No change for Year 2.</td>
</tr>
<tr>
<td></td>
<td>• 92 activities in the Inventory.</td>
<td>Number of activities:</td>
</tr>
<tr>
<td></td>
<td>• Small practices; practices in rural areas, geographic health professional shortage areas (HPSAs); and non-patient facing MIPS eligible clinicians don’t need more than 2 activities (2 medium or 1 high-weighted activity) to earn the full score.</td>
<td>• Finalized more activities and changes to existing activities; for a total of approximately 112 activities in the inventory.</td>
</tr>
<tr>
<td></td>
<td>• All other MIPS eligible clinicians don’t need more than 4 activities (4 medium or 2 high-weighted activities, or a combination).</td>
<td>• No change for Year 2 in the requirements for small practices, practices in rural areas, geographic HPSAs, and non-patient facing MIPS eligible clinicians</td>
</tr>
<tr>
<td></td>
<td>Definition of certified patient-centered medical home:</td>
<td>• No change for Year 2 in the number of activities that you need to report to reach a maximum of 40 points.</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
<td>Definition of certified patient-centered medical home:</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
<td>• Finalized the term “recognized” to mean the same as “certified” as a patient-centered medical home or comparable specialty practice.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Finalized a 50% threshold for 2018 for the number of practice sites within a TIN that need to be patient-centered medical homes for that TIN to get full credit for the Improvement Activities performance category.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Scoring:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No change for Year 2 to the scoring policy for APMs and MIPS APMs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Kept some activities in the performance category that also qualify for an Advancing Care Information bonus.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For group participation, only 1 MIPS eligible clinician in a TIN has to perform the Improvement Activity for the TIN to get credit.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Allow simple attestation of Improvement Activities.</td>
</tr>
<tr>
<td><strong>MIPS Policy</strong></td>
<td><strong>Performance Year 1 (2017)</strong></td>
<td><strong>Performance Year 2 (2018)</strong></td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
</tr>
</tbody>
</table>
| **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. | **Weight to final score:**  
• No change for Year 2 |
| **Advancing Care Information Performance Measure** | **Weight to final score:**  
25%, made up of a base score, performance score, and bonus points for data submission on certain measures and activities.  
**CEHRT requirements:**  
• Can use either 2014 or 2015 Edition CEHRT for the 2017 transition year.  
**Scoring:**  
• Award a base score of 50% if you submit the numerator (of at least “1”) and denominator, or “yes” for the yes/no measure, for each required measure. If the base score isn’t met, you’ll get a 0 for the Advancing Care Information category.  
• Awarded performance score points if you submit additional measures (up to 10% each).  
• Give a bonus score (5%) for submitting to 1 or more additional public health agencies or clinical data registries.  
• Give bonus points (10%) when you use CEHRT to complete at least 1 of the specified Improvement Activities. | **CEHRT requirements:**  
• No change for Year 2 for the 2020 payment year.  
• A 10% bonus is available if you only use the 2015 Edition CEHRT.  
**Scoring:**  
• No change for Year 2 to the base score requirements for the 2020 payment year.  
• For the performance score, you or your group may earn 10% in the performance score for reporting to any single public health agency or clinical data registry.  
• A 5% bonus score is available for submitting to an additional public health agency or clinical data registry not reported under the performance score.  
• Additional Improvement Activities are eligible for a 10% Advancing Care Information bonus if you use CEHRT to complete at least 1 of the specified Improvement Activities.  
• A 10% bonus score for using 2015 Edition exclusively.  
**Exceptions:**  
• Based on authority from the 21st Century Cures Act, we’ll reweight the Advancing Care Information performance category to 0% of the final score and reallocate the performance category weight of 25% to the Quality performance category for:  
  o A significant hardship exception—won’t apply a 5-year limit to this exception;  
  o A new significant hardship exception for MIPS eligible clinicians in small practices (15 or fewer clinicians);  
  o An exception for hospital-based MIPS eligible clinicians; |
|------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Exceptions                   | Reweighted the Advancing Care Information performance category to 0% of the final score and reallocate the weight to the Quality performance category if there are not sufficient measures applicable and available for a clinician. | o A new exception for Ambulatory Surgical Center (ASC)-based MIPS eligible clinicians, finalized to apply beginning with the transition year; and  
  o A new exception for MIPS eligible clinicians whose EHR was decertified.  
  • New deadline of December 31 of the performance period for the submission of reweighting applications, beginning with the 2017 performance 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 (POS 19). |
| Complex patients bonus       | Not available in 2017                                                                                                                                                                                                       | Clinicians can earn up to 5 bonus points 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 2017                                                                                                                                                                                                       | Added 5 points to any MIPS eligible clinician or small group who’s in a small practice (defined as 15 or fewer eligible clinicians), as long as the MIPS eligible clinician or group submits data on at least 1 performance category in an applicable performance period. |
| Final score                  | 2017 MIPS performance period final score: Quality 60%, Cost 0%, Improvement Activities 15%, and Advancing Care Information 25%                                                                                           | 2018 MIPS performance year final score: Quality 50%, Cost 10%, Improvement Activities 15%, and Advancing Care Information 25%                                                                                           |
| Performance threshold/ Payment adjustment | • Performance threshold is set at 3 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. | • Performance threshold set at 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 3) as required by law.  
  • Additional payment adjustment calculation is the same as in 2017.  
  • Payment adjustment will be applied to the amount Medicare pays. |
| Performance period            | • Minimum 90-day performance period for Quality, Advancing Care Information, and Improvement Activities.                                                                                                                  | • No change for Year 2 for Advancing Care Information, Improvement Activities, and Cost performance periods.  
  • Minimum 12-month performance period for Quality.  
  • No change for Year 2 to the exception. |

Measures and Objectives:  
• We have finalized exclusions for the E-Prescribing and Health Information Exchange Measures, for the transition year.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Exception: measures through CMS Web Interface, CAHPS, and the readmission measure are for 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cost measured for 12 months.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
25. **What are Advanced Alternative Payment Models (Advanced APMs)?**

An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. Advanced APMs are a subset of APMs, and are the second path to payment under MACRA’s Quality Payment Program. They allow practices to earn more for taking on some risk related to their patients’ outcomes.

As defined by MACRA, APMs include CMS Innovation Center models, Medicare Shared Savings Program, demonstrations under the Health Care Quality Demonstration Program, and demonstrations required by federal law.

There are new Advanced APMs expected to be available for participation in 2018, including the Medicare ACO Track 1 Plus (1+) Model, and the addition of new participants for some current Advanced APMs, such as the Next Generation ACO Model and Comprehensive Primary Care Plus (CPC+) Model.

To be an Advanced APM, an APM must meet the following three criteria:

- Require participants to use certified EHR technology (CEHRT)
- Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS), and
- Either: (1) be a Medical Home Model expanded under CMS Innovation Center authority; or (2) require that participating APM Entities bear more than a nominal amount of financial risk.

Once you are in an Advanced APM, you'll earn the 5% incentive payment in 2020 for Advanced APM participation in 2018 if:

- You receive 25% of your Medicare Part B payments through an Advanced APM or
- You see 20% of your Medicare patients through an Advanced APM

Earning an incentive payment in one year does not guarantee receiving the incentive payment in future years.

**Note:** CMS will publish a final list of Advanced APMs before January 1, 2018. Due to the requirements that Advanced APM participants carry more than nominal risk and use CEHRT, this path to payment will NOT be an option for the vast majority of behavioral health providers. Read more about Advanced APMs in the Quality Payment Program [here](#).

26. **How do I join an Advanced APM?**

CMS has established a website for clinicians to learn about specific Advanced APMs and how to apply. You can apply to an Advanced APM that fits your practice and is currently accepting applications.
27. How are incentive payments calculated for clinicians who participate in an Advanced APM?
If you receive 25% of your Medicare Part B payments or see 20% of your Medicare patients through an Advanced APM in 2018, then you earn a 5% incentive payment in 2020. Positive, neutral or negative payment adjustments will begin in 2020. The timeline for advanced APM adjustments appears below. The size of your payment adjustment will depend both on how much data you submit and your quality results.

28. What are the Quality Payment Program 2018 Year 2 APM Highlights?

Better Coordination and Promoting Alignment
The final rule more closely aligns the standards that apply to Medicare and Other Payer Advanced APMS. Specific policies include:

- Establishing a generally applicable revenue-based nominal amount standard for Other Payer Advanced APMS. This standard allows a non-Medicare payment arrangement to meet the financial risk criterion to qualify as an Other Payer Advanced APM if participants are required to bear total risk of at least 8% of their revenues from a given payer.

Increasing APM Participation
This year’s rule includes provisions to make it easier for eligible clinicians to participate in select APMS (known as Advanced APMS), which may allow them to qualify for incentive payments. Specific policies include:

- Extending the 8% generally applicable revenue based nominal amount standard that allows APMS to qualify as Advanced APM for two additional years, through performance year 2020
- Exempting Round 1 Comprehensive Primary Care Plus participants certain currently participating clinicians from the 50 clinician limit on organizations that can earn incentive payments by participating in medical home models
- Changing the requirement for Medical Home Models so that the minimum required amount of total financial risk increases more slowly
- Making it easier for clinicians to qualify for incentive payments by participating in Advanced APMS that begin or end in the middle of a year.

Reducing Complexity

- More detail on how eligible clinicians participating in selected APMS (known as MIPS APMS) will be assessed under the APM scoring standard. This special standard reduces burden for MIPS APMS participants who do not qualify as Qualifying APM Participants (QPs), and are therefore subject to MIPS.
- Elaborated on how the All-Payer Combination Option will be implemented. This option allows clinicians to become QPs through a combination of Medicare participation in Advanced APMS and participation in Other Payer Advanced APMS. Where possible, CMS created additional flexibilities and pathways to allow clinicians to be successful under the All Payer Combination Option. This option will be available beginning in performance year 2019.
29. What are the differences between Year 1 (2017) and Year 2 (2018) of the Quality Payment Program for Advanced APMs?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally applicable nominal amount standard</td>
<td>Total potential risk under the APM must be equal to at least: either 8% of the average estimated Parts A and B revenue of the participating APM Entities for the QP performance period in 2017 and 2018 (the revenue-based standard), OR 3% of the expected expenditures that an APM Entity is responsible for under the APM for all performance years.</td>
<td>• Extended the 8% revenue-based standard for 2 additional years, through performance year 2020.</td>
</tr>
<tr>
<td>Medical Home Model financial risk standard</td>
<td>Starting in the 2018, QP performance period, the Medical Home Model financial risk standard wouldn’t apply for APM Entities that are owned and operated by organizations with more than 50 eligible clinicians.</td>
<td>Keeping the “50 eligible clinician cap” in place except for clinicians who are participating in the first round of the Comprehensive Primary Care Plus (CPC+) model.</td>
</tr>
</tbody>
</table>
| Medical Home Model nominal amount standard | The total potential risk for an APM Entity under the Medical Home Model standard has to be equal to at least:  
  • 2.5% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2017.  
  • 3% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2018.  
  • 4% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2019.  
  • 5% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2020. | Finalizing that the minimum total potential risk for an APM Entity under the Medical Home Model standard is adjusted to:  
  • 2.5% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities for performance year 2018.  
  • 3% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities for the QP performance period in 2019.  
  • 4% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities for performance year 2020.  
  • 5% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities for performance years 2021 and after. |
| Qualifying APM participant (QP) performance period & QP & partial QP determination | • Beginning in 2017, the QP performance period will be January 1 – August 31 each year.  
  • CMS will make 3 QP determinations using data from March 31, through June 30, and through the last day of the QP performance period, respectively. | • No change for Year 2 for the QP performance period  
  • The timeframe on which the payment/patient threshold calculations is based is modified for certain Advanced APMs. For Advanced APMs that start or end during the QP performance period, QP Threshold Scores are calculated using only the dates that APM Entities were able to participate in the Advanced APM, as long as they were able to participate for at least 60 continuous days during the QP performance period. |
30. **Will the "pick your pace" with MACRA reporting continue in 2018?**

Year 2 (2018) of the program uses many of the flexibilities of the transition year but not all, therefore for 2018, CMS does not use the phrase "pick your pace." Review the comparison chart on the final rule fact sheet for a full list of flexibilities [here](#).

31. **Where should I go for help with the Quality Payment Program?**

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

*Primary Care & Specialist Physicians* – Transforming Clinical Practice Initiative (TCPI): TCPI is designed to support more than 140,000 clinician practices over four years in sharing, adapting, and further developing their comprehensive quality improvement strategies. Clinicians participating in TCPI will have the advantage of learning about MIPS and how to move toward participating in Advanced APMs. Click [here](#) to find help in your area.

*Small & Solo Practices* – Small, Underserved, and Rural Support (SERS) provides outreach, guidance, and direct technical assistance to clinicians in solo or small practices (15 or fewer), particularly those in rural and underserved areas to promote successful health IT adoption, optimization, and delivery system reform activities. For more information, contact QPPSURS@IMPAQINT.COM

*Large Practices* – Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs): The QIO Program’s 14 QIN-QIOs bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. More information about QIN-QIOs can be found [here](#).

*Technical Support* – All Eligible Clinicians are supported by the Quality Payment Program Website: [www.qpp.cms.gov](http://www.qpp.cms.gov) CMS is continuously developing new materials. The best way to find out when they will be released is to sign up for the QPP List Serve on [www.qpp.cms.gov](http://www.qpp.cms.gov)

32. **If I have additional questions, who should I contact?**

Please contact Dana Foney at DanaF@TheNationalCouncil.org. You can find additional resources at [www.TheNationalCouncil.org/MACRA](http://www.TheNationalCouncil.org/MACRA).