



Dear Medicare Clinician:

Thank you for your participation in Medicare and the services you provide to people with Medicare. You're an integral part of the dedicated team of clinicians who serve more than 55 million people with Medicare. The clinician-patient relationship is central to our work at the Centers for Medicare & Medicaid Services and we continuously work to reduce the administrative burdens you may face when participating in Medicare programs. During this first year of transition to the Quality Payment Program, we have put together several program options, so you can choose the pace that best meets your practice needs. However, we know we can do more and are committed to diligently working with you over the next year to streamline the process as much as possible. Our goal is to further reduce burdensome requirements so that you can deliver the best possible care to patients. Our doors are open and we look forward to hearing your ideas and receiving your feedback so we can make additional improvements in year two of the Quality Payment Program.

Why am I getting this letter?

You have a practice identified by a taxpayer identification number (TIN) enrolled in Medicare. Starting in 2017, clinicians will participate in the new Quality Payment Program as a group or individually either through the Merit-based Incentive Payment System (MIPS) or participation in an Advanced Alternative Payment Model (APM). **This letter lets you know if your group and the individuals in your group (if those individuals choose to report separately to the program) are exempt from MIPS because of the following:**

- being a low-volume clinician (being below established program thresholds); or
- not being among the categories of clinicians included in the program in the first year.

In addition, you may be exempt from MIPS if you are:

- a new Medicare enrolled clinician; or
- if you are participating in certain Advanced Alternative Payment Models and your participation is sufficient to meet certain thresholds.

Attachment A provides low-volume and non-eligible provider type information in a list for each clinician and group.

MIPS replaces the Physician Quality Reporting System (PQRS), Value Modifier (VM) and the Medicare EHR Incentive Program for eligible clinicians who provide items and services under Medicare Part B. The Quality Payment Program will provide new tools and resources to help you give your patients the best possible, highest-value care. Even better, you could receive positive payment adjustments based on your participation, performance, and engaging in improvement activities. Clinicians who practice under multiple TINs will be notified at the TIN level of their eligibility, and may have different eligibilities for each TIN/practice.

This is the first year of this new program. Based on stakeholder feedback, we have made it much easier to participate in the program from the start. We reduced the number of proposed requirements and created a variety of timelines, so you can pick when you want to start and your pace of participation.

What do I need to do?

Review Attachment A. Determine whether you plan to participate as a group or if clinicians within your group will participate individually. If you participate in an Alternative Payment Model (APM), reach out to your model's support inbox to learn more information about additional support that is available.

Let the clinicians assigned to your TIN know if they're included in MIPS or exempt from MIPS if individual clinician participation is chosen as the method of participation.

- **If included in MIPS, the clinician:**
 - Must participate to potentially earn an upward adjustment and avoid a negative adjustment to their Medicare Part B payments.
 - Can participate as an individual or as part of their group.
 - Can pick the pace of their participation for the first performance period. If they're ready, they can collect performance data beginning with services that were furnished beginning on January 1, 2017. Clinicians can also choose to start anytime between January 1 and October 2, 2017.
 - Must submit any MIPS data to Medicare no later than March 31, 2018 to qualify for a positive or neutral payment adjustment, which will affect their 2019 Medicare Part B payments, and avoid up to a 4% negative payment adjustment in 2019.

- **If the clinician is not included in MIPS, the clinician:**
 - Won't be subject to a positive or negative Medicare Part B payment adjustment in 2019 under MIPS.
 - No further action is required unless your TIN decides to participate as a group and is above one of the low volume thresholds.
 - May choose to voluntarily submit data individually to Medicare to learn, to obtain feedback on quality measures, and to prepare in the event MIPS is expanded in the future. Clinicians who submit data voluntarily will not be subject to a positive or negative payment adjustment.

- **If the clinician is a participant in an Advanced APM, the clinician:**
 - Should determine and confirm participation in the Advanced APM (visit <http://go.cms.gov/APMlist> to see an up to date list of Advanced APMs).
 - Should continue to fulfill the participation requirements of the Advanced APM. The Quality Payment Program does NOT change how any particular Advanced APM rewards value or operates, and Advanced APMs have their own quality reporting and participation requirements.
 - Should know that there are special benefits for those who meet threshold levels of participation in an Advanced APM for a year. These benefits include exemption from the MIPS reporting and payment adjustments, and a 5% lump sum APM incentive payment, if CMS determines the clinician is a Qualifying APM Participant (QP) in any one of three determinations conducted throughout a performance year. A clinician can become a QP by participating in an Advanced APM and reaching the thresholds for sufficient Medicare Part B payments or Medicare patients through the Advanced APM.
 - Should know that eligible clinicians participating in Advanced APMs who do not meet the threshold to be QPs may qualify as a Partial Qualifying APM Participant (Partial QP) if they meet certain minimum thresholds of Medicare Part B payments or Medicare patients through the Advanced APM. Partial QPs can elect to report to MIPS and be subject to MIPS payment adjustments, or not to report to MIPS, and be excluded from MIPS payment adjustments.
 - Should know that MIPS eligible clinicians participating in Advanced APMs who do not meet the threshold to be QPs or Partial QPs will be subject to MIPS. However, they may receive special MIPS scoring considerations.
 - Should consider the impact under the Quality Payment Program if the clinician wants to exit the Advanced APM during the year, as exiting early could nullify these benefits.

If your TIN would like to report MIPS data as a group, the group will get one MIPS final score based on the group's performance. You should plan your participation and let the eligible clinicians assigned to your TIN know what they need to do for your group to successfully participate in MIPS. If you participate as a group, you'll be assessed as a group across all MIPS performance categories.

Get help & more information

Attachment B has further guidance, including helpful questions and answers about the Quality Payment Program. If you need more help, you can also:

- **Visit** qpp.cms.gov for helpful resources or
- **Contact the** Quality Payment Program at QPP@cms.hhs.gov or **1-866-288-8292** (Monday-Friday 8AM-8PM ET) to find local help in your community. **TTY** users can call **1-877-715-6222**.

SAMPLE

Attachment A: Who’s included and should actively participate in MIPS to avoid a penalty and possibly earn a positive adjustment

<TIN>

Reference # QPP201701

<PROVIDER NAME>

<DATE>

<PROVIDER ADDRESS>

Below is a list of the clinician(s) associated with your TIN, their National Provider Identifier(s) (NPI), and whether they are subject to the Merit-Based Incentive Payment System (MIPS).

Inclusion in MIPS is based on a number of factors, including whether the group or the individual clinician exceeds the low volume threshold criteria. Under this criteria, you will be exempt from MIPS if you bill Medicare less than \$30,000 a year or provide care for less than 100 Medicare patients a year.

Note, however, that if your group chooses to report as a group, MIPS assessment will be based on all individuals in the group, and the payment adjustment will include those clinicians who do not exceed the low-volume threshold as individuals.

If you are currently subject to MIPS, please prepare to participate in the program; we will notify you of any changes in your participation status.

This information should be shared with the clinicians associated with your TIN. If you have questions, please call the Quality Payment Program at 1-866-288-8292 (Monday-Friday 8AM-8PM ET). TTY users can call 1-877-715-6222.

TIN	NPI	MIPS Participation
*****		Included in MIPS; OR
		Your group fell below threshold for Medicare Part B payments or patients
	#####	Included in MIPS
	#####	Exempt from MIPS. Below threshold for Medicare Part B payments or patients, unless participating as a Group.
	#####	Exempt from MIPS. Not an eligible provider type.

Please note, clinicians who practice under multiple TINs will be notified at the TIN level of their eligibility and therefore may have different eligibilities for each of their TIN/practice combinations.

Attachment B: Important Questions & Answers

What is the Quality Payment Program?

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

The Quality Payment Program has two tracks:

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

What is MIPS?

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

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

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

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

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

Who is included in MIPS?

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

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

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

What is Pick Your Pace?

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

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

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

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

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

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

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

How was my eligibility determined?

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

What is the low-volume threshold?

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

Is it possible for my group to be below the threshold?

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

Should our practice report as a group or as individuals? Where can I get more help to make the best choice?

Practices should visit qpp.cms.gov to find more information related to the participation options under MIPS.

How do I know if I'm in an Advanced APM and therefore possibly exempt from MIPS?

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

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

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

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

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

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

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

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

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

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