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Exemptions and Special Status Determinations under the Merit-Based Incentive Payment System (MIPS): A Resource Guide for Existing and Proposed Policies

The following tables provide information on exemptions and "special status" determinations under the Merit-Based Incentive Payment System (MIPS).

- Table 1: MIPS Exemptions. Individual clinicians and groups that meet criteria for the listed exemptions are not considered MIPS eligible clinicians and are exempt from MIPS reporting and participation requirements, as well as from MIPS payment adjustments.
- Table 2: MIPS Special Status Determinations. Individuals and groups who meet the criteria for a "special status" determination are still subject to MIPS reporting and participation requirements, in addition to MIPS payment adjustments; however, they receive special reporting and/or scoring accommodations under MIPS.

This guide does not provide details regarding treatment under the Advanced Alternative Payment Model track of the Quality Payment Program.

Table 1: MIPS Exemptions

Exemption	Individual Determination	Group Determination	Treatment under MIPS Already Finalized	Proposed Treatment under CY 2018 QPP
EXEMPTIONS				
Low-Volume	For 2017: An eligible clinician who has Medicare Part B allowed charges less than or equal to $30,000 or provides care for 100 or fewer Part B-enrolled Medicare beneficiaries. For 2018 (proposed): An eligible clinician who has Medicare Part B allowed charges less than or equal to $90,000 or provides care for 200 or fewer Part B-enrolled Medicare beneficiaries.	For 2017: A group that has Medicare Part B allowed charges less than or equal to $30,000 or provides care for 100 or fewer Part B-enrolled Medicare beneficiaries. For 2018 (proposed): A group that has Medicare Part B allowed charges less than or equal to $90,000 or provides care for 200 or fewer Part B-enrolled Medicare beneficiaries. This determination would not be made at the virtual group level.	Generally exempt from MIPS reporting and participation requirements, as well as from MIPS payment adjustments. For clinicians who are below the low-volume threshold but who choose to report as part of a group, they will be included in the determination of group performance and be subject to MIPS payment adjustments based on TIN performance.	Same as 2017, except that, for clinicians who are below the low-volume threshold and participate as part of a virtual group, the MIPS payment adjustment would not apply.
New Medicare-Enrolled MIPS Eligible Clinician	For 2017 and 2018 (maintained): An eligible clinician who first becomes a	For 2017 and 2018 (maintained): Not applicable.	Generally exempt from MIPS reporting and participation	Same as 2017, except that, for clinicians whose TINs are part of a virtual group, the MIPS

Exemption	Individual Determination	Group Determination	Treatment under MIPS Already Finalized	Proposed Treatment under CY 2018 QPP
		EXEMPTIONS		
	Medicare-enrolled eligible clinician within the Provider Enrollment, Chain and Ownership System (PECOS) during the performance period for a year and had not previously submitted claims under Medicare as an individual, an entity, or a part of a physician group or under a different billing number or tax identifier.		requirements, as well as from MIPS payment adjustments. For eligible clinicians who are new Medicare-enrolled MIPS eligible clinicians who are part of a group, their performance will be included in the determination of group performance, but payments for items and services furnished by such clinicians would not be subject to a MIPS payment adjustment.	payment adjustment would not apply.
Qualifying APM Participant (QP)	For 2017 and 2018 (maintained): An eligible clinician determined by CMS to have met or exceeded the relevant QP payment amount or QP patient count thresholds for participation in an advanced alternative payment model (Advanced APM) specified in statute and regulation.	For 2017 and 2018 (maintained): Not applicable.	Exempt from MIPS reporting and participation requirements, as well as from MIPS payment adjustments. Additional non-MIPS payment policies apply.	Same as 2017.
Partial Qualifying APM Participant (Partial QP)	For 2017 and 2018 (maintained): An eligible clinician determined by CMS to have met the relevant Partial QP thresholds for participation in an Advanced APM specified in statute and regulation. Such amounts show substantial participation, but not enough to achieve QP status.	For 2017 and 2018 (maintained): Not applicable.	Exempt from MIPS reporting and participation requirements, as well as from MIPS payment adjustments, unless the Partial QP chooses to report under MIPS. In that case, full reporting and participation requirements apply, as do MIPS payment adjustments.	Same as 2017, including with respect to participation via a virtual group.

Table 2: MIPS Special Status Determinations

Special Status	Individual Determination	Group Determination	Treatment under MIPS Already Finalized	Proposed Treatment under CY 2018 QPP
SPECIAL STATUS DETERMINATIONS				
Small Practice	For 2017 and 2018 (maintained): An eligible clinician who furnishes items or services as part of a practice consisting of 15 or fewer clinicians, or a solo practitioner.	For 2017 and 2018 (maintained): A practice consisting of 2 to 15 clinicians.	Quality category: Exempt from assessment under the all-cause hospital readmission measure. Improvement Activities (IA) category: Subject to reduced reporting requirements, such that individuals or groups who are in a small practice only have to report one high-weighted IA or two medium-weighted IAs to receive full credit under this category.	Same as 2017, plus the following: Quality category: Maintains a 3-point floor for quality measures reported that do not meet data completeness requirements. Advancing Care Information (ACI): Can qualify for a new small practice hardship exemption with an approved application. Final score: Eligible for small practice bonus of 5 points added to final score. Virtual groups: Virtual groups with fewer than 15 clinicians may qualify as a small practice.
Rural Area	For 2017: A clinician in a TIN with at least one practice site in a zip code designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health resource File data set available.	For 2017: A TIN with at least one practice site in a zip code designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health resource File data set available.[1] For 2018 (proposed): a TIN with at least 75 percent of NPIs	IA category: Subject to reduced reporting requirements, such that individuals or groups who are in a small practice only have to report one high-weighted IA or two medium-weighted IAs to receive full credit under this category.	Same as 2017, except that virtual groups with at least 75 percent of their TINs designated as rural areas would also be designated as a rural area at the virtual group level.

[1] This is based on clarifications included in the CY 2018 Updates to the QPP Proposed Rule. Separately, CMS notes on its website that a group qualifies for the rural designation if the "practice has at least one clinician that is designated as rural."

Special Status	Individual Determination	Group Determination	Treatment under MIPS Already Finalized	Proposed Treatment under CY 2018 QPP
SPECIAL STATUS DETERMINATIONS				
	For 2018 (proposed): a clinician in a TIN with at least 75 percent of NPIs billing under the TIN located in a zip code designated as rural, using the most recent HRSA resource File data set available.	billing under the TIN located in a zip code designated as rural, using the most recent HRSA resource File data set available.		
Health Professional Shortage Area (HPSA)	For 2017: A clinician in a TIN with at least one practice site in an area designated as a HPSA under section 332(a)(1)(A) of the public Health Service Act. For 2018 (proposed): A clinician in a TIN with at least 75 percent of NPIs billing under the TIN located in an HPSA.	For 2017: A TIN with at least one practice site in an area designated as a HPSA under section 332(a)(1)(A) of the public Health Service Act.[2] For 2018 (proposed): A TIN with at least 75 percent of NPIs billing under the TIN located in an HPSA.	IA category: Subject to reduced reporting requirements, such that individuals or groups who are in a small practice only have to report one high-weighted IA or two medium-weighted IAs to receive full credit under this category.	Same as 2017, except that virtual groups with at least 75 percent of their TINs designated as HPSA practices would also be designated as an HPSA practice at the virtual group level.
Non-Patient Facing	For 2017 and 2018 (maintained): An individual MIPS eligible clinician that bills 100 or fewer patient facing encounters (including Medicare telehealth services) during the non-patient facing determination period.	For 2017 and 2018 (maintained): A group where more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period.	IA category: Subject to reduced reporting requirements, such that individuals or groups who are in a small practice only have to report one high-weighted IA or two medium-weighted IAs to receive full credit under this category. Advancing Care Information (ACI) category: Subject to automatic reweighting of this category to zero percent,	Same as 2017, except that virtual groups with at least 75 percent of the NPIs billing under the virtual group's TINs would also meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period.

[2] This is based on clarifications included in the CY 2018 Updates to the QPP Proposed Rule. Separately, CMS notes on its website that a group qualifies for the HPSA designation if the "practice has at least one clinician that is designated as Health Professional Shortage Area."

Special Status	Individual Determination	Group Determination	Treatment under MIPS Already Finalized	Proposed Treatment under CY 2018 QPP
SPECIAL STATUS DETERMINATIONS				
			unless a non-patient facing clinician or group chooses to report under this category.	
Hospital-Based	For 2017: MIPS eligible clinicians who furnishes 75 percent or more of their covered professional services in sites of service identified by POS 21 (inpatient hospital), POS 22 (on-campus outpatient hospital), or emergency room (POS 23) setting based on claims for a period prior to the performance period as specified by CMS. For 2018 (proposed): Same as 2017, except that CMS proposes to also include services provided in sites of service identified by POS 19 (off-campus outpatient hospital) in the definition of hospital-based MIPS eligible clinician.	For 2017 and 2018 (maintained): A group where 100 percent of its clinicians are determined to be hospital-based.	ACI category: Subject to automatic reweighting of this category to zero percent, unless a hospital-based MIPS eligible clinician chooses to report under this category. For a hospital-based MIPS eligible clinician who reports as part of a group, the group is not required to report any information for that individual and his/her performance will be removed from the group's numerator and denominator, unless the group reports data for such clinician.	Same as 2017.
Ambulatory Surgical Center (ASC)-Based	For 2017 onward (proposed): MIPS eligible clinicians who furnish 75% or more of their covered professional services in sites of service identified by POS 24 (ASC), based on claims for a prior period as specified by CMS.	For 2017 onward (proposed): Not specified in the CY 2018 proposed QPP rule.	Not applicable.	Advancing Care Information: Subject to automatic reweighting of this category to zero percent, unless an ASC-based MIPS eligible clinician chooses to report under this category. CMS does not specify reporting requirements for an ASC-based clinician who reports

Special Status	Individual Determination	Group Determination	Treatment under MIPS Already Finalized	Proposed Treatment under CY 2018 QPP
SPECIAL STATUS DETERMINATIONS				
				as part of a group in the CY 2018 proposed rule.
Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, or Certified Registered Nurse Anesthetists	For 2017 and 2018: MIPS eligible clinicians who are physician assistants, nurse practitioners, clinical nurse specialists, or certified registered nurse anesthetists	For 2017 and 2018 (maintained): TBD. Awaiting CMS confirmation.	ACI category: Subject to automatic reweighting of this category to zero percent, unless the designated non-physician practitioner MIPS eligible clinician chooses to report under this category. For a MIPS eligible clinician who reports as part of a group, the group is not required to report any information for that individual and his/her performance will be removed from the group's numerator and denominator, unless the group reports data for such clinician.	Same as 2017.
Facility-Based	For 2018 (proposed): A MIPS eligible clinician who furnishes 75% or more of their covered professional services in sites of service identified by POS 21 (inpatient hospital) or POS 23 (emergency room), based on claims for a prior period as specified by CMS.	For 2018 (proposed): A group in which 75 percent or more of the MIPS eligible clinician NPIs billing under the group's TIN are eligible for facility-based measurement as individuals	Not applicable	May elect to be assessed under facility-based measurement for the cost and quality performance categories. This option is not available for virtual groups.
Virtual Group	Not applicable	For 2018 (proposed): A combination of two or more TINs composed of a solo practitioner or a group with 10 or fewer eligible clinicians	Not applicable	Subject to assessment at the virtual group level across all participating TINs for all four MIPS performance categories.

Special Status	Individual Determination	Group Determination	Treatment under MIPS Already Finalized	Proposed Treatment under CY 2018 QPP
SPECIAL STATUS DETERMINATIONS				
		under the TIN that elects to (and is approved to) form a virtual group with at least one other such solo practitioner or group for a performance period for a year.		The final score of a TIN/NPI combination assessed as a virtual group would be applied instead of the final score of a TIN/NPI combination assessed at the group or individual level. A virtual group that has 15 or fewer clinicians would qualify as a small practice.
MIPS APM Participant	For 2017 and 2018 (maintained): An individual clinician who is identified on the Participation List for a performance period of an APM Entity participating in a MIPS APM.	For 2017 and 2018 (maintained): The group of eligible clinicians identified on the Participation List for a performance period of an APM Entity participating in a MIPS APM.	A MIPS APM Entity group is subject to the APM Scoring Standard under MIPS, which generally: • Relies on quality reporting under the MIPS APM for the quality reporting category • Assigns a minimum IA score based on activities required for participation under the model (in practice thus far, this has translated to being assigned 100% of the points available under the IA category) • Aggregates TIN-level (for MSSP APM entities) or NPI-level (for all other MIPS APM entity groups) ACI reporting for all TINs/NPIs participating in an APM Entity • Reweights the cost category to zero and redistributes weight across the remaining categories.	Same as 2017, except: • All MIPS APMs are scored in the quality category and subject to the APM Scoring Standard category weights as those that applied for MIPS APMs that were scored in the quality category in 2017. • The final score of a TIN/NPI combination assessed under a MIPS APM would be applied instead of the final score of a TIN/NPI combination assessed at the virtual group level, as well as at the group or individual level.

<table>
<tr><th>Special Status</th><th>Individual Determination</th><th>Group Determination</th><th>Treatment under MIPS Already Finalized</th><th>Proposed Treatment under CY 2018 QPP</th></tr>
<tr><th colspan="5">SPECIAL STATUS DETERMINATIONS</th></tr>
<tr><td></td><td></td><td></td><td>For 2017, only those MIPS APMs that require reporting via the Web Interface[3] are scored in the quality category, with category weights shown in the table below. For other MIPS APMs, the quality category is reweighted to zero. Final category weights are specified by CMS for those without quality category weights.
<table><tr><th colspan="2">APM Scoring Standard Weights</th></tr><tr><td>Cost</td><td>0%</td></tr><tr><td>Quality</td><td>50%</td></tr><tr><td>Improvement Activities</td><td>20%</td></tr><tr><td>ACI</td><td>30%</td></tr></table>
The final score of a TIN/NPI combination assessed under a MIPS APM would be applied instead of the final score of a TIN/NPI combination assessed at the group or individual level.

For individual clinicians who are identified as MIPS APM participants, their participation in the MIPS APM would automatically provide one-half of the highest score under the</td><td></td></tr>
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[3] This includes MIPS APMs under the Medicare Shared Savings Program and the Next Generation ACO Model.

Special Status	Individual Determination	Group Determination	Treatment under MIPS Already Finalized	Proposed Treatment under CY 2018 QPP
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			IA performance category for any other TIN (besides the MIPS APM TIN) in which they participate given their status as an APM Participant.	
Certified Patient-Centered Medical Home (PCMH) or Comparable Specialty Practice	For 2017 and 2018 (maintained): A MIPS eligible clinician in a practice that is determined to be a certified or recognized PCMH or comparable specialty practice.[4] For 2017: To receive full credit as a certified patient-centered medical home or comparable specialty practice requires that a TIN that is reporting includes at least one practice which is a certified patient-centered medical home or comparable specialty practice. For 2018 (proposed): To receive full credit as a certified or recognized patient-centered medical home or comparable	For 2017 and 2018 (maintained): A group in a practice that is determined to be a certified or recognized PCMH or comparable specialty practice. For 2017: To receive full credit as a certified patient-centered medical home or comparable specialty practice requires that a TIN that is reporting includes at least one practice which is a certified patient-centered medical home or comparable specialty practice. For 2018 (proposed): To receive full credit as a certified or recognized patient-centered medical home or comparable	Receives full credit for performance under the IA category.	Same as 2017, except that the certified patient-centered medical home designation may also apply to qualifying virtual groups.

[4] To meet the PCMH requirement, a practice must meet one of the following criteria:
(*A) The practice has received accreditation from one of four accreditation organizations that are nationally recognized or certified, including (1) The Accreditation Association for Ambulatory Health Care; (2) The National Committee for Quality Assurance (NCQA); (3) The Joint Commission; or (4) The Utilization Review Accreditation Commission (URAC).*
(B) The practice is participating in a Medicaid Medical Home Model or Medical Home Model.
(C) The practice is a comparable specialty practice that has received the NCQA Patient-Centered Specialty Recognition.
(D) The practice has received accreditation from other certifying bodies that have certified a large number of medical organizations and meet national guidelines, as determined by the Secretary. The Secretary must determine that these certifying bodies must have 500 or more certified member practices, and require practices to include the following: (1) Have a personal physician/clinician in a team-based practice; (2) Have a whole-person orientation; (3) Provide coordination or integrated care; (4) Focus on quality and safety; and (5) Provide enhanced access. Note that In the CY 2018 QPP rule, CMS proposes that the term "recognized" be accepted as equivalent to the term "certified."

Special Status	Individual Determination	Group Determination	Treatment under MIPS Already Finalized	Proposed Treatment under CY 2018 QPP
SPECIAL STATUS DETERMINATIONS				
	specialty practice, at least 50% of the practice sites within the TIN must be recognized as a patient-centered medical home or comparable specialty practice.	specialty practice, at least 50% of the practice sites within the TIN must be recognized as a patient-centered medical home or comparable specialty practice.		
APM Participant	For 2017 and 2018 (maintained): A clinician identified on the Participation List of an APM.	For 2017 and 2018 (maintained): A group where one clinician in the TIN is identified on the Participation List of an APM.	Receives at least one-half of the highest score under the IA performance category.	Same as 2017, except that a virtual group may be identified as an APM participant per the group determination.