the calculation of the value-based payment modifier.

[77 FR 69368, Nov. 16, 2012, as amended at 79 FR 68008, Nov. 13, 2014]

Subpart O—Merit-Based Incentive Payment System and Alternative Payment Model Incentive

SOURCE: 81 FR 77537, Nov. 4, 2016, unless otherwise noted.

§ 414.1300 Basis and scope.

(a) *Basis*. This subpart implements the following provisions of the Act:

(1) Section 1833(z)—Incentive Payments for Participation in Eligible Alternative Payment Models.

(2) Section 1848(a)—Payment for Physicians' Services Based on Fee Schedule.

(3) Section 1848(k)—Quality Reporting System.

(4) Section 1848(q)—Merit-based Incentive Payment System.

(b) *Scope*. This subpart part sets forth the following:

(1) The circumstances under which eligible clinicians are not considered MIPS eligible clinicians with respect to a year.

(2) How individual MIPS eligible clinicians can have their performance assessed as a group.

(3) The data submission methods and data submission criteria for each of the MIPS performance categories.

(4) Methods for calculating a performance category score for each of the MIPS performance categories.

(5) Methods for calculating a MIPS final score and applying the MIPS payment adjustment to MIPS eligible clinicians.

(6) Requirements for an APM to be designated an ''Advanced APM.''

(7) Methods for eligible clinicians and entities participating in Advanced APMs to meet the participation thresholds to become Qualifying APM Participants (QPs) and Partial QPs.

(8) Methods and processes for counting participation in Other Payer Advanced APMs in making QP and Partial QP determinations.

(9) Methods for calculating and paying the APM Incentive Payment to QPs.

(10) Criteria for Physician-Focused Payment Models (PFPMs).

§ 414.1305 Definitions.

As used in this section, unless otherwise indicated—

Additional performance threshold means the numerical threshold for a MIPS payment year against which the final scores of MIPS eligible clinicians are compared to determine the additional MIPS payment adjustment factors for exceptional performance.

Advanced Alternative Payment Model (Advanced APM) means an APM that CMS determines meets the criteria set forth in § 414.1415.

Affiliated practitioner means an eligible clinician identified by a unique APM participant identifier on a CMS-maintained list who has a contractual relationship with the APM Entity for the purposes of supporting the APM Entity's quality or cost goals under the Advanced APM.

Affiliated practitioner list means the list of Affiliated Practitioners of an APM Entity that is compiled from a CMS-maintained list.

Alternative Payment Model (APM) means any of the following:

(1) A model under section 1115A of the Act (other than a health care innovation award).

(2) The shared savings program under section 1899 of the Act.

(3) A demonstration under section 1866C of the Act.

(4) A demonstration required by Federal law.

Ambulatory Surgical Center (ASC)-based MIPS eligible clinician means:

(1) For the 2019 and 2020 MIPS payment years, a MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the Place of Service (POS) codes used in the HIPAA standard transaction as an ambulatory surgical center setting based on claims for a period prior to the performance period as specified by CMS; and

(2) Beginning with the 2021 MIPS payment year, a MIPS eligible clinician who furnishes 75 percent or more

of his or her covered professional services in sites of service identified by the POS codes used in the HIPAA standard transaction as an ambulatory surgical center setting based on claims for the MIPS determination period.

APM Entity means an entity that participates in an APM or other payer arrangement through a direct agreement with CMS or an other payer or through Federal or State law or regulation.

APM Entity group means the group of eligible clinicians participating in an APM Entity, as identified by a combination of the APM identifier, APM Entity identifier, Taxpayer Identification Number (TIN), and National Provider Identifier (NPI) for each participating eligible clinician.

APM Incentive Payment means the lump sum incentive payment for a year paid to an eligible clinician who is a QP for the year from 2019 through 2024.

Attestation means a secure mechanism, specified by CMS, with respect to a particular performance period, whereby a MIPS eligible clinician or group may submit the required data for the advancing care information or the improvement activities performance categories of MIPS in a manner specified by CMS.

Attributed beneficiary means a beneficiary attributed to the APM Entity under the terms of the Advanced APM as indicated on the most recent available list of attributed beneficiaries at the time of a QP determination.

Attribution-eligible beneficiary means a beneficiary who during the QP Performance Period:

(1) Is not enrolled in Medicare Advantage or a Medicare cost plan;

(2) Does not have Medicare as a secondary payer;

(3) Is enrolled in both Medicare Parts A and B;

(4) Is at least 18 years of age;

(5) Is a United States resident; and

(6) Has a minimum of one claim for evaluation and management services furnished by an eligible clinician who is in the APM Entity for any period during the QP Performance Period or, for an Advanced APM that does not base attribution on evaluation and management services and for which attributed beneficiaries are not a subset of the attribution-eligible beneficiary population based on the requirement to have at least one claim for evaluation and management services furnished by an eligible clinician who is in the APM Entity for any period during the QP Performance Period, the attribution basis determined by CMS based upon the methodology the Advanced APM uses for attribution, which may include a combination of evaluation and management and/or other services.

Certified Electronic Health Record Technology (CEHRT) means the following:

(1) For any calendar year before 2019, EHR technology (which could include multiple technologies) certified under the ONC Health IT Certification Program that meets one of the following:

(i) The 2014 Edition Base EHR definition (as defined at 45 CFR 170.102) and that has been certified to the certification criteria that are necessary to report on applicable objectives and measures specified for the MIPS advancing care information performance category, including the applicable measure calculation certification criterion at 45 CFR 170.314(g)(1) or (2) for all certification criteria that support an objective with a percentage-based measure.

(ii) Certification to—

(A) The following certification criteria:

(*1*) CPOE at—

(*i*) 45 CFR 170.314(a)(1), (18), (19) or (20); or

(*ii*) 45 CFR 170.315(a)(1), (2) or (3).

(*2*)(*i*) Record demographics at 45 CFR 170.314(a)(3); or

(*ii*) 45 CFR 170.315(a)(5).

(*3*)(*i*) Problem list at 45 CFR 170.314(a)(5); or

(*ii*) 45 CFR 170.315(a)(6).

(*4*)(*i*) Medication list at 45 CFR 170.314(a)(6); or

(*ii*) 45 CFR 170.315(a)(7).

(*5*)(*i*) Medication allergy list 45 CFR 170.314(a)(7); or

(*ii*) 45 CFR 170.315(a)(8).

(*6*)(*i*) Clinical decision support at 45 CFR 170.314(a)(8); or

(*ii*) 45 CFR 170.315(a)(9).

(*7*) Health information exchange at transitions of care at one of the following:

(*i*) 45 CFR 170.314(b)(1) and (2).

(*ii*) 45 CFR 170.314(b)(1), (b)(2), and (h)(1).

(*iii*) 45 CFR 170.314(b)(1), (b)(2), and (b)(8).

(*iv*) 45 CFR 170.314(b)(1), (b)(2), (b)(8), and (h)(1).

(*v*) 45 CFR 170.314(b)(8) and (h)(1).

(*vi*) 45 CFR 170.314(b)(1), (b)(2), and 170.315(h)(2).

(*vii*) 45 CFR 170.314(b)(1), (b)(2), (h)(1), and 170.315(h)(2).

(*viii*) 45 CFR 170.314(b)(1), (b)(2), (b)(8), and 170.315(h)(2).

(*ix*) 45 CFR 170.314(b)(1), (b)(2), (b)(8), (h)(1), and 170.315(h)(2).

(*x*) 45 CFR 170.314(b)(8), (h)(1), and 170.315(h)(2).

(*xi*) 45 CFR 170.314(b)(1), (b)(2), and 170.315(b)(1).

(*xii*) 45 CFR 170.314(b)(1), (b)(2), (h)(1), and 170.315(b)(1).

(*xiii*) 45 CFR 170.314(b)(1), (b)(2), (b)(8), and 170.315(b)(1).

(*xiv*) 45 CFR 170.314(b)(1), (b)(2), (b)(8), (h)(1), and 170.315(b)(1).

(*xv*) 45 CFR 170.314(b)(8), (h)(1), and 170.315(b)(1).

(*xvi*) 45 CFR 170.314(b)(1), (b)(2), (b)(8), (h)(1), 170.315(b)(1), and 170.315(h)(1).

(*xvii*) 45 CFR 170.314(b)(1), (b)(2), (b)(8), (h)(1), 170.315(b)(1), and 170.315(h)(2).

(*xviii*) 45 CFR 170.314(h)(1) and 170.315(b)(1).

(*xix*) 45 CFR 170.315(b)(1) and (h)(1).

(*xx*) 45 CFR 170.315(b)(1) and (h)(2).

(*xxi*) 45 CFR 170.315(b)(1), (h)(1), and (h)(2); and

(B) Clinical quality measures at—

(*1*) 45 CFR 170.314(c)(1) or 170.315(c)(1);

(*2*) 45 CFR 170.314(c)(2) or 170.315(c)(2);

(*3*) Clinical quality measure certification criteria that support the calculation and reporting of clinical quality measures at 45 CFR 170.314(c)(2) and (3) and optionally (4); or 45 CFR 170.315(c)(3)(i) and (ii) and optionally (c)(4); and can be electronically accepted by CMS if the data is submitted electronically.

(C) Privacy and security at—

(*1*) 45 CFR 170.314(d)(1) or 170.315(d)(1);

(*2*) 45 CFR 170.314(d)(2) or 170.315(d)(2);

(*3*) 45 CFR 170.314(d)(3) or 170.315(d)(3);

(*4*) 45 CFR 170.314(d)(4) or 170.315(d)(4);

(*5*) 45 CFR 170.314(d)(5) or 170.315(d)(5);

(*6*) 45 CFR 170.314(d)(6) or 170.315(d)(6);

(*7*) 45 CFR 170.314(d)(7) or 170.315(d)(7);

(*8*) 45 CFR 170.314(d)(8) or 170.315(d)(8); and

(D) The certification criteria that are necessary to report on applicable objectives and measures specified for the MIPS advancing care information performance category, including the applicable measure calculation certification criterion at 45 CFR 170.314(g)(1) or (2) or 45 CFR 170.315(g)(1) or (2) for all certification criteria that support an objective with a percentage-based measure.

(iii) The definition for 2019 and subsequent years specified in paragraph (2) of this definition.

(2) For 2019 and subsequent years, EHR technology (which could include multiple technologies) certified under the ONC Health IT Certification Program that meets the 2015 Edition Base EHR definition (as defined at 45 CFR 170.102) and has been certified to the 2015 Edition health IT certification criteria—

(i) At 45 CFR 170.315(a)(12) (family health history) and 45 CFR 170.315(e)(3) (patient health information capture); and

(ii) Necessary to report on applicable objectives and measures specified for the MIPS advancing care information performance category including the following:

(A) The applicable measure calculation certification criterion at 45 CFR 170.315(g)(1) or (2) for all certification criteria that support an objective with a percentage-based measure.

(B) Clinical quality measure certification criteria that support the calculation and reporting of clinical quality measures at 45 CFR 170.315(c)(2) and (c)(3)(i) and (ii) and optionally (c)(4), and can be electronically accepted by CMS.

CMS-approved survey vendor means a survey vendor that is approved by CMS for a particular performance period to administer the CAHPS for MIPS survey and to transmit survey measures data to CMS.

CMS Multi-Payer Model means an Advanced APM that CMS determines, per the terms of the Advanced APM, has at least one other payer arrangement that is designed to align with the terms of that Advanced APM.

CMS Web Interface means a web product developed by CMS that is used by groups that have elected to utilize the

CMS Web Interface to submit data on the MIPS measures and activities.

Collection type means a set of quality measures with comparable specifications and data completeness criteria, as applicable, including, but not limited to: electronic clinical quality measures (eCQMs); MIPS Clinical Quality Measures (MIPS CQMs), QCDR measures, Medicare Part B claims measures, CMS Web Interface measures, the CAHPS for MIPS survey, and administrative claims measures.

Covered professional services has the meaning given by section 1848(k)(3)(A) of the Act.

Eligible clinician means ''eligible professional'' as defined in section 1848(k)(3) of the Act, as identified by a unique TIN and NPI combination and, includes any of the following:

(1) A physician.

(2) A practitioner described in section 1842(b)(18)(C) of the Act.

(3) A physical or occupational therapist or a qualified speech-language pathologist.

(4) A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).

Episode payment model means an APM or other payer arrangement designed to improve the efficiency and quality of care for an episode of care by bundling payment for services furnished to an individual over a defined period of time for a specific clinical condition or conditions.

Estimated aggregate payment amounts means the total payments to a QP for Medicare Part B covered professional services for the incentive payment base period, estimated by CMS as described in §414.1450(b).

Facility-based MIPS eligible clinician means an individual MIPS eligible clinician who furnishes 75 percent or more of their covered professional services (as defined in section 1848(k)(3)(A) of the Act) in sites of service identified by the Place of Service (POS) codes used in the HIPAA standard transaction as an inpatient hospital, as identified by POS code 21, or an emergency room, as identified by POS code 23, based on claims during the facility-based determination period, and a group provided that more than 75 percent of the NPIs billing under the group's TIN meet the definition of a facility-based individual MIPS eligible clinician during the facility-based determination period.

Final score means a composite assessment (using a scoring scale of 0 to 100) for each MIPS eligible clinician for a performance period determined using the methodology for assessing the total performance of a MIPS eligible clinician according to performance standards for applicable measures and activities for each performance category.

Full TIN APM means an APM where participation is determined at the TIN level, and all eligible clinicians who have assigned their billing rights to a participating TIN are therefore participating in the APM.

Group means a single TIN with two or more eligible clinicians (including at least one MIPS eligible clinician), as identified by their individual NPI, who have reassigned their billing rights to the TIN.

Health IT vendor means an entity that supports the health IT requirements on behalf of a MIPS eligible clinician (including obtaining data from a MIPS eligible clinician's CEHRT).

Health Professional Shortage Areas (HPSA) means areas as designated under section 332(a)(1)(A) of the Public Health Service Act.

High priority measure means:

(1) For the 2019 and 2020 MIPS payment years, an outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, or care coordination quality measure.

(2) Beginning with the 2021 MIPS payment year, an outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure.

Hospital-based MIPS eligible clinician means:

(1) For the 2019 and 2020 MIPS payment years, a MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the Place of Service (POS) codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient

hospital, off campus-outpatient hospital, or emergency room setting based on claims for a period prior to the performance period as specified by CMS; and

(2) Beginning with the 2021 MIPS payment year, a MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the POS codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, off campus outpatient hospital, or emergency room setting based on claims for the MIPS determination period.

Improvement activities means an activity that relevant MIPS eligible clinician, organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

Improvement scoring means an assessment measuring improvement for each MIPS eligible clinician or group for a performance period using a methodology that compares improvement from one performance period to another performance period.

Incentive payment base period means the calendar year prior to the year in which CMS disburses the APM Incentive Payment.

Low-volume threshold means:

(1) For the 2019 MIPS payment year, the low-volume threshold that applies to an individual eligible clinician, group, or APM Entity group that, during the low-volume threshold determination period described in paragraph (4) of this definition, has Medicare Part B allowed charges less than or equal to $30,000 or provides care for 100 or fewer Medicare Part B-enrolled individuals.

(2) For the 2020 MIPS payment year, the low-volume threshold that applies to an individual eligible clinician, group, or APM Entity group that, during the low-volume threshold determination period described in paragraph (4) of this definition, has allowed charges for covered professional services less than or equal to $90,000 or furnishes covered professional services to 200 or fewer Medicare Part B-enrolled individuals.

(3) Beginning with the 2021 MIPS payment year, the low-volume threshold that applies to an individual eligible clinician, group, or APM Entity group that, during the MIPS determination period, has allowed charges for covered professional services less than or equal to $90,000, furnishes covered professional services to 200 or fewer Medicare Part B-enrolled individuals, or furnishes 200 or fewer covered professional services to Medicare Part B-enrolled individuals.

(4) For the 2019 and 2020 MIPS payment years, the low-volume threshold determination period is a 24-month assessment period consisting of:

(i) An initial 12-month segment that spans from the last 4 months of the calendar year 2 years prior to the performance period through the first 8 months of the calendar year preceding to the performance period; and

(ii) A second 12-month segment that spans from the last 4 months of the calendar year 1 year prior to the performance period through the first 8 months of the calendar year performance period. An individual eligible clinician, group, or APM Entity group that is identified as not exceeding the low-volume threshold during the initial 12-month segment will continue to be excluded under § 414.1310(b)(1)(iii) for the applicable year regardless of the results of the second 12-month segment analysis. For the 2019 MIPS payment year, each segment of the low-volume threshold determination period includes a 60-day claims run out. For the 2020 MIPS payment year, each segment of the low-volume threshold determination period includes a 30-day claims run out.

Meaningful EHR user for MIPS means a MIPS eligible clinician who possesses CEHRT, uses the functionality of CEHRT, and reports on applicable objectives and measures specified for the advancing care information performance category for a performance period in the form and manner specified by CMS, supports information exchange and the prevention of health information blocking, and engages in activities related to supporting providers with the performance of CEHRT.

Measure benchmark means the level of performance that the MIPS eligible clinician is assessed on for a specific performance period at the measures and activities level.

Medicaid APM means a payment arrangement authorized by a State Medicaid program that meets the Other Payer Advanced APM criteria set forth in §414.1420.

Medical Home Model means an APM under section 1115A of the Act that is determined by CMS to have the following characteristics:

(1) The APM has a primary care focus with participants that primarily include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, primary care focus means the inclusion of specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 16 Obstetrics and Gynecology; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant;

(2) Empanelment of each patient to a primary clinician; and

(3) At least four of the following:

(i) Planned coordination of chronic and preventive care.

(ii) Patient access and continuity of care.

(iii) Risk-stratified care management.

(iv) Coordination of care across the medical neighborhood.

(v) Patient and caregiver engagement.

(vi) Shared decision-making.

(vii) Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments).

Medicaid Medical Home Model means a payment arrangement under title XIX that CMS determines to have the following characteristics:

(1) The payment arrangement has a primary care focus with participants that primarily include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, primary care focus means the inclusion of specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 16 Obstetrics and Gynecology; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant;

(2) Empanelment of each patient to a primary clinician; and

(3) At least four of the following:

(i) Planned coordination of chronic and preventive care.

(ii) Patient access and continuity.

(iii) Risk-stratified care management.

(iv) Coordination of care across the medical neighborhood.

(v) Patient and caregiver engagement.

(vi) Shared decision-making.

(vii) Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments).

Merit-based Incentive Payment System (MIPS) means the program required by section 1848(q) of the Act.

MIPS APM means an APM that meets the criteria specified under §414.1370(b).

MIPS determination period means:

(1) Beginning with the 2021 MIPS payment year, a 24-month assessment period consisting of:

(i) An initial 12-month segment beginning on October 1 of the calendar year 2 years prior to the applicable performance period and ending on September 30 of the calendar year preceding the applicable performance period, and that includes a 30-day claims run out; and

(ii) A second 12-month segment beginning on October 1 of the calendar year preceding the applicable performance period and ending on September 30 of the calendar year in which the applicable performance period occurs.

(2) Subject to §414.1310(b)(1)(iii), an individual eligible clinician, group, or APM Entity group that is identified as not exceeding the low-volume threshold or as having special status during the first segment of the MIPS determination period will be identified as

such for the applicable MIPS payment year regardless of the results of the second segment of the MIPS determination period. An individual eligible clinician, group, or APM Entity group for which the unique billing TIN and NPI combination is established during the second segment of the MIPS determination period will be assessed based solely on the results of such segment.

MIPS eligible clinician as identified by a unique billing TIN and NPI combination used to assess performance, means any of the following (except as excluded under § 414.1310(b)):

(1) For the 2019 and 2020 MIPS payment years:

(i) A physician (as defined in section 1861(r) of the Act);

(ii) A physician assistant, a nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5) of the Act);

(iii) A certified registered nurse anesthetist (as defined in section 1861(bb)(2) of the Act); and

(iv) A group that includes such clinicians.

(2) For the 2021 MIPS payment year and future years:

(i) A clinician described in paragraph (1) of this definition;

(ii) A physical therapist or occupational therapist;

(iii) A qualified speech-language pathologist;

(iv) A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act);

(v) A clinical psychologist (as defined by the Secretary for purposes of section 1861(ii) of the Act);

(vi) A registered dietician or nutrition professional; and

(vii) A group that includes such clinicians.

MIPS payment year means a calendar year in which the MIPS payment adjustment factor, and if applicable the additional MIPS payment adjustment factor, are applied to Medicare Part B payments.

New Medicare-Enrolled MIPS eligible clinician means an eligible clinician who first becomes a 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.

Non-patient facing MIPS eligible clinician means:

(1) For the 2019 and 2020 MIPS payment year, an individual MIPS eligible clinician who bills 100 or fewer patient facing encounters (including Medicare telehealth services defined in section 1834(m) of the Act), as described in paragraph (3) of this definition, during the non-patient facing determination period described in paragraph (4) of this definition, and a group or virtual group provided that more than 75 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable, meet the definition of a non-patient facing individual MIPS eligible clinician.

(2) Beginning with the 2021 MIPS payment year, an individual MIPS eligible clinician who bills 100 or fewer patient facing encounters (including Medicare telehealth services defined in section 1834(m) of the Act), as described in paragraph (3) of this definition, during the MIPS determination period, and a group or virtual group provided that more than 75 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable, meet the definition of a non-patient facing individual MIPS eligible clinician.

(3) For purposes of this definition, a patient-facing encounter is an instance in which the individual MIPS eligible clinician or group bills for items and services furnished such as general office visits, outpatient visits, and procedure codes under the PFS, as specified by CMS.

(4) For the 2019 and 2020 MIPS payment year, the non-patient facing determination period is a 24-month assessment period consisting of:

(i) An initial 12-month segment that spans from the last 4 months of the calendar year 2 years prior to the performance period through the first 8 months of the calendar year preceding the performance period; and

(ii) A second 12-month segment that spans from the last 4 months of the calendar year 1 year prior to the performance period through the first 8 months

of the calendar year performance period. An individual eligible MIPS clinician, group, or virtual group that is identified as non-patient facing during the initial 12-month segment will continue to be considered non-patient facing for the applicable year regardless of the results of the second 12-month segment analysis. For the 2019 MIPS payment year, each segment of the non-patient facing determination period includes a 60-day claims run out. For the 2020 MIPS payment year and future years, each segment of the non-patient facing determination period includes a 30-day claims run out.

Other MIPS APM means a MIPS APM that does not require reporting through the CMS Web Interface.

Other Payer Advanced APM means an other payer arrangement that meets the Other Payer Advanced APM criteria set forth in §414.1420.

Other payer arrangement means a payment arrangement with any payer that is not an APM.

Partial Qualifying APM Participant (Partial QP) means an eligible clinician determined by CMS to have met the relevant Partial QP threshold under §414.1430(a)(2) and (4) and (b)(2) and (4) for a year.

Partial QP patient count threshold means the minimum threshold score specified in §414.1430(a)(4) and (b)(4) that an eligible clinician must attain through a patient count methodology described in §§414.1435(b) and 414.1440(c) to become a Partial QP for a year.

Partial QP payment amount threshold means the minimum threshold score specified in §414.1430(a)(2) and (b)(2) that an eligible clinician must attain through a payment amount methodology described §§414.1435(a) and 414.1440(b) to become a Partial QP for a year.

Participation List means the list of participants in an APM Entity that is compiled from a CMS-maintained list.

Performance category score means the assessment of each MIPS eligible clinician's performance on the applicable measures and activities for a performance category for a performance period based on the performance standards for those measures and activities.

Performance standards means the level of performance and methodology that the MIPS eligible clinician is assessed on for a MIPS performance period at the measures and activities level for all MIPS performance categories.

Performance threshold means the numerical threshold for a MIPS payment year against which the final scores of MIPS eligible clinicians are compared to determine the MIPS payment adjustment factors.

QP patient count threshold means the minimum threshold score specified in §414.1430(a)(3) and (b)(3) that an eligible clinician must attain through a patient count methodology described in §§414.1435(b) and 414.1440(c) to become a QP for a year.

QP payment amount threshold means the minimum threshold score specified in §414.1430(a)(1) and (b)(1) that an eligible clinician must attain through the payment amount methodology described in §§414.1435(a) and 414.1440(b) to become a QP for a year.

QP Performance Period means the time period that CMS will use to assess the level of participation by an eligible clinician in Advanced APMs and Other Payer Advanced APMs for purposes of making a QP determination for the eligible clinician for the year as specified in §414.1425. The QP Performance Period begins on January 1 and ends on August 31 of the calendar year that is 2 years prior to the payment year.

Qualified clinical data registry (QCDR) means:

(1) For the 2019, 2020 and 2021 MIPS payment year, a CMS-approved entity that has self-nominated and successfully completed a qualification process to determine whether the entity may collect medical or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.

(2) Beginning with the 2022 MIPS payment year, an entity that demonstrates clinical expertise in medicine and quality measurement development experience and collects medical or clinical data on behalf of a MIPS eligible clinician for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.

Qualified registry means a medical registry, a maintenance of certification program operated by a specialty

body of the American Board of Medical Specialties or other data intermediary that, with respect to a particular performance period, has self-nominated and successfully completed a vetting process (as specified by CMS) to demonstrate its compliance with the MIPS qualification requirements specified by CMS for that performance period. The registry must have the requisite legal authority to submit MIPS data (as specified by CMS) on behalf of a MIPS eligible clinician or group to CMS.

Qualifying APM participant (QP) means an eligible clinician determined by CMS to have met or exceeded the relevant QP payment amount or QP patient count threshold under § 414.1430(a)(1), (a)(3), (b)(1), or (b)(3) for a year based on participation in an APM Entity that is also participating in an Advanced APM.

Rural area means a ZIP code designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data set available.

Small practice means:

(1) For the 2019 MIPS payment year, a TIN consisting of 15 or fewer eligible clinicians.

(2) For the 2020 MIPS payment year, a TIN consisting of 15 or fewer eligible clinicians during a 12-month assessment period that spans from the last 4 months of the calendar year 2 years prior to the performance period through the first 8 months of the calendar year preceding the performance period and includes a 30-day claims run out.

(3) Beginning with the 2021 MIPS payment year, a TIN consisting of 15 or fewer eligible clinicians during the MIPS determination period.

Solo practitioner means a practice consisting of 1 eligible clinician (who is also a MIPS eligible clinician).

Submission type means the mechanism by which the submitter type submits data to CMS, including, but not limited to: Direct, log in and upload, log in and attest, Medicare Part B claims and the CMS Web Interface.

Submitter type means the MIPS eligible clinician, group, virtual group, or third party intermediary acting on behalf of a MIPS eligible clinician, group, or virtual group, as applicable, that submits data on measures and activities under MIPS.

Third party intermediary means an entity that has been approved under § 414.1400 to submit data on behalf of a MIPS eligible clinician, group, or virtual group for one or more of the quality, improvement activities, and promoting interoperability performance categories.

Threshold Score means the percentage value that CMS determines for an eligible clinician based on the calculations described in § 414.1435 or § 414.1440.

Topped out non-process measure means a measure where the Truncated Coefficient of Variation is less than 0.10 and the 75th and 90th percentiles are within 2 standard errors.

Topped out process measure means a measure with a median performance rate of 95 percent or higher.

Virtual group means a combination of two or more TINs assigned to one or more solo practitioners or to one or more groups consisting of 10 or fewer eligible clinicians, or both, that elect to form a virtual group for a performance period for a year.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53950, Nov. 16, 2017; 83 FR 60075, Nov. 23, 2018]

§ 414.1310 Applicability.

(a) *Program implementation.* Except as specified in paragraph (b) of this section, MIPS applies to payments for covered professional services furnished by MIPS eligible clinicians on or after January 1, 2019.

(b) *Exclusions.* (1) For a year, a MIPS eligible clinician does not include an eligible clinician who:

(i) Is a Qualifying APM Participant (as defined at § 414.1305);

(ii) Is a Partial Qualifying APM Participant and does not elect to participate in MIPS as a MIPS eligible clinician; or

(iii) Does not exceed the low-volume threshold. Beginning with the 2021 MIPS payment year, if an individual eligible clinician, group, or APM Entity group in a MIPS APM exceeds at least one, but not all, of the low-volume threshold criteria and elects to participate in MIPS as a MIPS eligible clinician, the individual eligible clinician, group, or APM Entity group is

treated as a MIPS eligible clinician for the applicable MIPS payment year. For such solo practitioners and groups that elect to participate in MIPS as a virtual group (except for APM Entity groups in MIPS APMs), the virtual group election under §414.1315 constitutes an election under this paragraph and results in the solo practitioners and groups being treated as MIPS eligible clinicians for the applicable MIPS payment year. For such APM Entity groups in MIPS APMs, only the APM Entity group election can result in the APM Entity group being treated as MIPS eligible clinicians for the applicable MIPS payment year.

(2) Eligible clinicians, as defined at §414.1305, who are not MIPS eligible clinicians, as defined at §414.1305, have the option to voluntarily report measures and activities for MIPS.

(c) *Treatment of new Medicare-enrolled eligible clinicians.* New Medicare-enrolled eligible clinician, as defined at §414.1305, will not be treated as a MIPS eligible clinician until the subsequent year and the performance period for such subsequent year.

(d) *Clarification.* In no case will a MIPS payment adjustment factor (or additional MIPS payment adjustment factor) apply to payments for items and services furnished during a year by a eligible clinician, including an eligible clinician described in paragraph (b) or (c) of this section, who is not a MIPS eligible clinician, including an eligible clinician who voluntarily reports on applicable measures and activities under MIPS.

(e) *Requirements for groups.* (1) Except as provided under §414.1370(f)(2), each MIPS eligible clinician in the group will receive a MIPS payment adjustment factor (or additional MIPS payment adjustment factor) based on the group's combined performance assessment.

(2) For individual MIPS eligible clinicians to participate in MIPS as a group, all of the following requirements must be met:

(i) Groups must meet the definition of a group at all times during the applicable performance period.

(ii) Individual eligible clinicians that elect to participate in MIPS as a group must aggregate their performance data across the group's TIN.

(iii) Individual eligible clinicians that elect to participate in MIPS as a group will have their performance assessed at the group level across all four MIPS performance categories.

(iv) Groups must adhere to an election process established by CMS, as applicable.

(3) Eligible clinicians and MIPS eligible clinicians within a group must aggregate their performance data across the TIN in order for their performance to be assessed as a group.

(4) A group that elects to have its performance assessed as a group will be assessed as a group across all four MIPS performance categories.

(5) A group must adhere to an election process established and required by CMS.

[81 FR 77537, Nov. 4, 2016, as amended at 83 FR 60076, Nov. 23, 2018]

§414.1315 Virtual groups.

(a) *Eligibility.* (1) For a MIPS payment year, a solo practitioner or a group of 10 or fewer eligible clinicians may elect to participate in MIPS as a virtual group with at least one other such solo practitioner or group. The election must be made prior to the start of the applicable performance period and cannot be changed during the performance period. A solo practitioner or group may elect to be in no more than one virtual group for a performance period, and, in the case of a group, the election applies to all MIPS eligible clinicians in the group.

(2) Except as provided under §414.1370(f)(2), each MIPS eligible clinician in the virtual group receives a MIPS payment adjustment factor and, if applicable, an additional MIPS payment adjustment factor based on the virtual group's combined performance assessment.

(b) *Election deadline.* The election deadline is December 31 of the calendar year preceding the applicable performance period.

(c) *Election process.* For the 2020 MIPS payment year and future years, the virtual group election process is as follows:

(1) *Stage 1: Virtual group eligibility determination.* (i) For the 2020 MIPS payment year, the virtual group eligibility determination period is an assessment period of up to 5 months beginning on July 1 and ending as late as November 30 of the calendar year preceding the applicable performance period, and that includes a 30-day claims run out.

(ii) Beginning with the 2021 MIPS payment year, the virtual group eligibility determination period is the first segment of the MIPS determination period.

(2) *Stage 2: Virtual group formation.* (i) Solo practitioners and groups that elect to participate in MIPS as a virtual group must establish a formal written agreement that satisfies paragraph (c)(3) of this section prior to the election.

(ii) A designated virtual group representative must submit an election, on behalf of the solo practitioners and groups that compose a virtual group, to participate in MIPS as a virtual group for a performance period in a form and manner specified by CMS by the election deadline specified in paragraph (b) of this section. The virtual group election must include each TIN and NPI associated with the virtual group and contact information for the virtual group representative.

(iii) After an election is made, the virtual group representative must contact their designated CMS contact to update any election information that changed during a performance period at least one time prior to the start of data submission.

(3) *Virtual group agreement.* The virtual group arrangement must be set forth in a formal written agreement among the parties, consisting of each solo practitioner and group that composes a virtual group. The agreement must comply with the following requirements:

(i) Identifies each party by name, TIN, and each NPI under the TIN, and includes as parties only the solo practitioners and groups that compose the virtual group.

(ii) Is for a term of at least one performance period.

(iii) Requires each party to notify each NPI under the party's TIN regarding their participation in the MIPS as a virtual group.

(iv) Sets forth each NPI's rights and obligations in, and representation by, the virtual group, including, but not limited to, the reporting requirements and how participation in the MIPS as a virtual group affects the NPI's ability to participate in the MIPS outside of the virtual group.

(v) Describes how the opportunity to receive payment adjustments will encourage each member of the virtual group (and each NPI under each TIN in the virtual group) to adhere to quality assurance and improvement.

(vi) Requires each party to update its Medicare enrollment information, including the addition or removal of NPIs billing under its TIN, on a timely basis in accordance with Medicare program requirements and to notify the other parties of any such changes within 30 days of the change.

(vii) Requires completion of a closeout process upon termination or expiration of the agreement that requires each party to furnish all data necessary for the parties to aggregate their data across the virtual group's TINs.

(viii) Expressly requires each party to participate in the MIPS as a virtual group and comply with the requirements of the MIPS and all other applicable laws (including, but not limited to, Federal criminal law, the Federal False Claims Act, the Federal antikickback statute, the Federal civil monetary penalties law, the Federal physician self-referral law, and the Health Insurance Portability and Accountability Act of 1996).

(ix) Is executed on behalf of each party by an individual who is authorized to bind the party.

(d) *Virtual group reporting requirements.* For solo practitioners and groups of 10 or fewer eligible clinicians to participate in MIPS as a virtual group, all of the following requirements must be met:

(1) Virtual groups must meet the definition of a virtual group at all times during the applicable performance period.

(2) Solo practitioners and groups of 10 or fewer eligible clinicians that elect to participate in MIPS as a virtual

group must aggregate their performance data across the virtual group's TINs.

(3) Solo practitioners and groups of 10 or fewer eligible clinicians that elect to participate in MIPS as a virtual group will have their performance assessed at the virtual group level across all four MIPS performance categories.

(4) Virtual groups must adhere to the election process described in paragraph (c) of this section.

[83 FR 60077, Nov. 23, 2018]

§414.1320 MIPS performance period.

(a) For purposes of the 2019 MIPS payment year, the performance period for all performance categories and submission mechanisms except for the cost performance category and data for the quality performance category reported through the CMS Web Interface, for the CAHPS for MIPS survey, and for the all-cause hospital readmission measure, is a minimum of a continuous 90-day period within CY 2017, up to and including the full CY 2017 (January 1, 2017 through December 31, 2017). For purposes of the 2019 MIPS payment year, for data reported through the CMS Web Interface or the CAHPS for MIPS survey and administrative claims-based cost and quality measures, the performance period under MIPS is CY 2017 (January 1, 2017 through December 31, 2017).

(b) For purposes of the 2020 MIPS payment year, the performance period for:

(1) The quality and cost performance categories is CY 2018 (January 1, 2018 through December 31, 2018).

(2) Promoting Interoperability and improvement activities performance categories is a minimum of a continuous 90-day period within CY 2018, up to and including the full CY 2018 (January 1, 2018 through December 31, 2018).

(c) For purposes of the 2021 MIPS payment year, the performance period for:

(1) The quality and cost performance categories is CY 2019 (January 1, 2019 through December 31, 2019).

(2) Promoting Interoperability and improvement activities performance categories is a minimum of a continuous 90-day period within CY 2019, up to and including the full CY 2019 (January 1, 2019 through December 31, 2019).

(d) Beginning with the 2022 MIPS payment year, the performance period for:

(1) The quality and cost performance categories is the full calendar year (January 1 through December 31) that occurs 2 years prior to the applicable MIPS payment year.

(2) The improvement activities performance categories is a minimum of a continuous 90-day period within the calendar year that occurs 2 years prior to the applicable MIPS payment year, up to and including the full calendar year.

(e) For purposes of the 2022 MIPS payment year, the performance period for:

(1) The Promoting Interoperability performance category is a minimum of a continuous 90-day period within the calendar year that occurs 2 years prior to the applicable MIPS payment year, up to and including the full calendar year.

(2) [Reserved]

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53953, Nov. 16, 2017; 83 FR 60078, Nov. 23, 2018]

§414.1325 Data submission requirements.

(a) *Applicable performance categories.* (1) Except as provided in paragraph (a)(2) of this section or under §414.1370, as applicable, individual MIPS eligible clinicians and groups must submit data on measures and activities for the quality, improvement activities, and Promoting Interoperability performance categories in accordance with this section. Except for the Medicare Part B claims submission type, the data may also be submitted on behalf of the individual MIPS eligible clinician or group by a third party intermediary described at §414.1400.

(2) There are no data submission requirements for:

(i) The cost performance category or administrative claims-based quality measures. Performance in the cost performance category and on such measures is calculated by CMS using administrative claims data, which includes claims submitted with dates of service

during the applicable performance period that are processed no later than 60 days following the close of the applicable performance period.

(ii) The quality and cost performance categories, as applicable, for MIPS eligible clinicians and groups that are scored under the facility-based measurement scoring methodology described in § 414.1380(e).

(b) *Data submission types for individual MIPS eligible clinicians.* An individual MIPS eligible clinician may submit their MIPS data using:

(1) For the quality performance category, the direct, login and upload, and Medicare Part B claims (beginning with the 2021 MIPS payment year for small practices only) submission types.

(2) For the improvement activities or Promoting Interoperability performance categories, the direct, login and upload, or login and attest submission types.

(c) *Data submission types for groups.* Groups may submit their MIPS data using:

(1) For the quality performance category, the direct, login and upload, Medicare Part B claims (beginning with the 2021 MIPS payment year, for small practices only), and CMS Web Interface (for groups consisting of 25 or more eligible clinicians or a third party intermediary submitting on behalf of a group) submission types.

(2) For the improvement activities or Promoting Interoperability performance categories, the direct, login and upload, or login and attest submission types.

(d) *Use of multiple data submission types.* Beginning with the 2021 MIPS payment year, MIPS eligible clinicians, groups, and virtual groups may submit their MIPS data using multiple data submission types for any performance category described in paragraph (a)(1) of this section, as applicable; provided, however, that the MIPS eligible clinician, group, or virtual group uses the same identifier for all performance categories and all data submissions.

(e) *Data submission deadlines.* The data submission deadlines are as follows:

(1) For the direct, login and upload, login and attest, and CMS Web Interface submission types, March 31 following the close of the applicable performance period or a later date as specified by CMS.

(2) For the Medicare Part B claims submission type, data must be submitted on claims with dates of service during the applicable performance period that must be processed no later than 60 days following the close of the applicable performance period.

[83 FR 60078, Nov. 23, 2018]

§ 414.1330 Quality performance category.

(a) For a MIPS payment year, CMS uses the following quality measures, as applicable, to assess performance in the quality performance category:

(1) Measures included in the MIPS final list of quality measures established by CMS through rulemaking;

(2) QCDR measures approved by CMS under § 414.1400;

(3) Facility-based measures described in § 414.1380; and

(4) MIPS APM measures described in § 414.1370.

(b) Unless a different scoring weight is assigned by CMS, performance in the quality performance category comprises:

(1) 60 percent of a MIPS eligible clinician's final score for MIPS payment year 2019.

(2) 50 percent of a MIPS eligible clinician's final score for MIPS payment year 2020.

(3) 45 percent of a MIPS eligible clinician's final score for MIPS payment year 2021.

[83 FR 60078, Nov. 23, 2018]

§ 414.1335 Data submission criteria for the quality performance category.

(a) *Criteria.* A MIPS eligible clinician or group must submit data on MIPS quality measures in one of the following manners, as applicable:

(1) *For Medicare Part B claims measures, MIPS CQMs, eCQMs, or QCDR measures.* (i) Except as provided in paragraph (a)(1)(ii) of this section, submit data on at least six measures, including at least one outcome measure. If an applicable outcome measure is not available, report one other high priority measure. If fewer than six measures apply to the MIPS eligible

clinician or group, report on each measure that is applicable.

(ii) MIPS eligible clinicians and groups that report on a specialty or subspecialty measure set, as designated in the MIPS final list of quality measures established by CMS through rulemaking, must submit data on at least six measures within that set, including at least one outcome measure. If an applicable outcome measure is not available, report one other high priority measure. If the set contains fewer than six measures or if fewer than six measures within the set apply to the MIPS eligible clinician or group, report on each measure that is applicable.

(2) *For CMS Web Interface measures.* (i) Report on all measures included in the CMS Web Interface. The group is required to report on at least one measure for which there is Medicare patient data.

(ii) [Reserved]

(3) *For the CAHPS for MIPS survey.* (i) For the 12-month performance period, a group that wishes to voluntarily elect to participate in the CAHPS for MIPS survey must use a survey vendor that is approved by CMS for the applicable performance period to transmit survey measures data to CMS.

(ii) [Reserved]

(b) [Reserved]

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53953, Nov. 16, 2017; 83 FR 60079, Nov. 23, 2018]

§414.1340 Data completeness criteria for the quality performance category.

(a) MIPS eligible clinicians and groups submitting quality measures data on QCDR measures, MIPS CQMs, or eCQMs must submit data on:

(1) At least 50 percent of the MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer for the MIPS payment years 2019.

(2) At least 60 percent of the MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer for the MIPS payment years 2020 and 2021.

(b) MIPS eligible clinicians and groups submitting quality measure data on Medicare Part B claims measures must submit data on:

(1) At least 50 percent of the applicable Medicare Part B patients seen during the performance period to which the measure applies for MIPS payment years 2019.

(2) At least 60 percent of the applicable Medicare Part B patients seen during the performance period to which the measure applies for MIPS payment years 2020 and 2021.

(c) Groups submitting quality measures data on CMS Web Interface measures or the CAHPS for MIPS survey must submit data on the sample of the Medicare Part B patients CMS provides, as applicable.

(1) *For CMS Web Interface measures.* (i) The group must report on the first 248 consecutively ranked beneficiaries in the sample for each measure or module. If the sample of eligible assigned beneficiaries is less than 248, then the group must report on 100 percent of assigned beneficiaries.

(ii) [Reserved]

(2) [Reserved]

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53953, Nov. 16, 2017; 83 FR 60079, Nov. 23, 2018]

§414.1350 Cost performance category.

(a) *Specification of cost measures.* For purposes of assessing performance of MIPS eligible clinicians on the cost performance category, CMS specifies cost measures for a performance period.

(b) *Attribution.* (1) Cost measures are attributed at the TIN/NPI level.

(2) For the total per capita cost measure, beneficiaries are attributed using a method generally consistent with the method of assignment of beneficiaries under §425.402 of this chapter.

(3) For the Medicare Spending per Beneficiary (MSPB) measure, an episode is attributed to the MIPS eligible clinician who submitted the plurality of claims (as measured by allowed charges) for Medicare Part B services rendered during an inpatient hospitalization that is an index admission for the MSPB measure during the applicable performance period.

(4) For the acute condition episode-based measures specified for the 2017

performance period, an episode is attributed to each MIPS eligible clinician who bills at least 30 percent of inpatient evaluation and management (E&M) visits during the trigger event for the episode.

(5) For the procedural episode-based measures specified for the 2017 performance period, an episode is attributed to each MIPS eligible clinician who bills a Medicare Part B claim with a trigger code during the trigger event for the episode.

(6) For the acute inpatient medical condition episode-based measures specified beginning with the 2019 performance period, an episode is attributed to each MIPS eligible clinician who bills inpatient E&M claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30 percent of the inpatient E&M claim lines in that hospitalization.

(7) For the procedural episode-based measures specified beginning with the 2019 performance period, an episode is attributed to each MIPS eligible clinician who renders a trigger service as identified by HCPCS/CPT procedure codes.

(c) *Case minimums.* (1) For the total per capita cost measure, the case minimum is 20.

(2) For the Medicare spending per beneficiary measure, the case minimum is 35.

(3) For the episode-based measures specified for the 2017 performance period, the case minimum is 20.

(4) For the procedural episode-based measures specified beginning with the 2019 performance period, the case minimum is 10.

(5) For the acute inpatient medical condition episode-based measures specified beginning with the 2019 performance period, the case minimum is 20.

(d) *Scoring weight.* Unless a different scoring weight is assigned by CMS under section 1848(q)(5)(F) of the Act, performance in the cost performance category comprises:

(1) Zero percent of a MIPS eligible clinician's final score for MIPS payment year 2019.

(2) 10 percent of a MIPS eligible clinician's final score for MIPS payment year 2020.

(3) 15 percent of a MIPS eligible clinician's final score for MIPS payment year 2021.

[83 FR 60079, Nov. 23, 2018]]

§ 414.1355 Improvement activities performance category.

(a) For a MIPS payment year, CMS uses improvement activities included in the MIPS final inventory of improvement activities established by CMS through rulemaking to assess performance in the improvement activities performance category.

(b) Unless a different scoring weight is assigned by CMS under section 1848(q)(5)(F) of the Act, performance in the improvement activities performance category comprises:

(1) 15 percent of a MIPS eligible clinician's final score for MIPS payment year 2019 and for each MIPS payment year thereafter.

(2) [Reserved].

(c) The following are the list of subcategories, of which, with the exception of Participation in an APM, include activities for selection by a MIPS eligible clinician or group:

(1) Expanded practice access, such as same day appointments for urgent needs and after-hours access to clinician advice.

(2) Population management, such as monitoring health conditions of individuals to provide timely health care interventions or participation in a QCDR.

(3) Care coordination, such as timely communication of test results, timely exchange of clinical information to patients or other clinicians, and use of remote monitoring or telehealth.

(4) Beneficiary engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision making mechanisms.

(5) Patient safety and practice assessment, such as through the use of clinical or surgical checklists and practice assessments related to maintaining certification.

(6) Participation in an APM.

(7) Achieving health equity, such as for MIPS eligible clinicians that achieve high quality for underserved

populations, including persons with behavioral health conditions, racial and ethnic minorities, sexual and gender minorities, people with disabilities, people living in rural areas, and people in geographic HPSAs.

(8) Emergency preparedness and response, such as measuring MIPS eligible clinician participation in the Medical Reserve Corps, measuring registration in the Emergency System for Advance Registration of Volunteer Health Professionals, measuring relevant reserve and active duty uniformed services MIPS eligible clinician activities, and measuring MIPS eligible clinician volunteer participation in domestic or international humanitarian medical relief work.

(9) Integrated behavioral and mental health, such as measuring or evaluating such practices as: Co-location of behavioral health and primary care services; shared/integrated behavioral health and primary care records; cross training of MIPS eligible clinicians, and integrating behavioral health with primary care to address substance use disorders or other behavioral health conditions, as well as integrating mental health with primary care.

[81 FR 77537, Nov. 4, 2016, as amended at 83 FR 60079, Nov. 23, 2018]

§414.1360 Data submission criteria for the improvement activities performance category.

(a) For purposes of the transition year of MIPS and future years, MIPS eligible clinicians or groups must submit data on MIPS improvement activities in one of the following manners:

(1) *Via direct, login and upload, and login and attest.* For the applicable performance period, submit a yes response for each improvement activity that is performed for at least a continuous 90-day period during the applicable performance period.

(i) Submit a yes response for activities within the improvement activities inventory.

(ii) [Reserved]

(2) [Reserved]

(b) [Reserved]

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53953, Nov. 16, 2017; 83 FR 60080, Nov. 23, 2018]

§414.1370 APM scoring standard under MIPS.

(a) *General.* The APM scoring standard is the MIPS scoring methodology applicable for MIPS eligible clinicians identified on the Participation List for the performance period of an APM Entity participating in a MIPS APM.

(b) *Criteria for MIPS APMs.* MIPS APMs are those in which:

(1) APM Entities participate in the APM under an agreement with CMS or through a law or regulation;

(2) The APM is designed such that APM Entities participating in the APM include at least one MIPS eligible clinician on a Participation List;

(3) The APM bases payment on quality measures and cost/utilization; and

(4) The APM is not either of the following:

(i) *New APMs.* An APM for which the first performance year begins after the first day of the MIPS performance period for the year.

(ii) *APM in final year of operation for which the APM scoring standard is impracticable.* An APM in the final year of operation for which CMS determines, within 60 days after the beginning of the MIPS performance period for the year, that it is impracticable for APM Entity groups to report to MIPS using the APM scoring standard.

(c) *APM scoring standard performance period.* The MIPS performance period under §414.1320 applies for the APM scoring standard.

(d) *APM participant identifier.* The APM participant identifier for an eligible clinician is the combination of four identifiers:

(1) APM identifier (established for the APM by CMS);

(2) APM Entity identifier (established for the APM Entity by CMS);

(3) Medicare-enrolled billing TIN; and

(4) Eligible clinician NPI.

(e) *APM Entity group determination.* For the APM scoring standard, the APM Entity group is determined in the manner prescribed in §414.1425(b)(1).

(1) *Full TIN APM.* In addition to the dates set forth in §414.1425(b)(1), the APM Entity group includes an eligible clinician who is on a Participation List in a Full TIN APM on December 31 of the MIPS performance period.

(2) [Reserved]

(f) *APM Entity group scoring under the APM scoring standard.* The MIPS final score calculated for the APM Entity is applied to each MIPS eligible clinician in the APM Entity group. The MIPS payment adjustment is applied at the TIN/NPI level for each of the MIPS eligible clinicians in the APM Entity group.

(1) If a Shared Savings Program ACO does not report data on quality measures as required by the Shared Savings Program under § 425.508 of this chapter, each ACO participant TIN will be treated as a unique APM Entity for purposes of the APM scoring standard and the ACO participant TINs may report data for the MIPS quality performance category according to the MIPS submission and reporting requirements.

(2) MIPS eligible clinicians who participate in a group or have elected to participate in a virtual group and who are also on a MIPS APM Participation List will be included in the assessment under MIPS for purposes of producing a group or virtual group score and under the APM scoring standard for purposes of producing an APM Entity score. The MIPS payment adjustment for these eligible clinicians is based solely on their APM Entity score; if the APM Entity group is exempt from MIPS all eligible clinicians within that APM Entity group are also exempt from MIPS.

(g) *MIPS performance category scoring under the APM scoring standard*—(1) *Quality*—(i) *MIPS APMs that require APM Entities to submit quality data using the CMS Web Interface.* (A) *Quality Performance Category Score.* The quality performance category score for a MIPS performance period is calculated for the APM Entity using the data submitted by the APM Entity according to the terms of the MIPS APM, including data on measures submitted through the CMS Web Interface and other measures specified by CMS through notice and comment rulemaking for the APM scoring standard.

(B) *Quality Improvement Score.* Beginning in 2018, for an APM Entity for which CMS calculated a total quality performance category score for one or more participants in the APM Entity for the previous MIPS performance period, CMS calculates a quality improvement score for the APM Entity group as specified in § 414.1380(b)(1)(xvi).

(C) *Total Quality Performance Category Score.* Beginning in 2018, the total quality performance category score is the sum of the quality performance category score, all applicable bonus points provided for by § 414.1380(b), and the quality improvement score.

(ii) *Other MIPS APMs*—(A) *Quality Performance Category Score.* The MIPS quality performance category score for a MIPS performance period is calculated for the APM Entity using the data submitted by the APM Entity based on measures specified by CMS through notice and comment rulemaking for each Other MIPS APM from among those used under the terms of the Other MIPS APM, and which are:

(*1*) Tied to payment;

(*2*) Available for scoring;

(*3*) Have a minimum of 20 cases available for reporting; and

(*4*) Have an available benchmark.

(B) *Quality Improvement Score.* Beginning in 2018, for an APM Entity for which CMS calculated a total quality performance category score for the previous MIPS performance period, CMS calculates a quality improvement score for the APM Entity group, as specified in § 414.1380(b)(1)(xvi).

(C) *Total Quality Performance Category Score.* Beginning in 2018, the total quality performance category score is the sum of the quality performance category score, all applicable bonus points provided by § 414.1380(b), and the quality improvement score.

(2) *Cost.* The cost performance category weight is zero percent for APM Entities in MIPS APMs.

(3) *Improvement activities.* (i) CMS assigns an improvement activities score for each MIPS APM for a MIPS performance period based on the requirements of the MIPS APM. The assigned improvement activities score applies to each APM Entity group for the MIPS performance period. In the event that the assigned score does not represent the maximum improvement activities score, an APM Entity may report additional activities.

(ii) [Reserved]

(4) *Promoting Interoperability.* (i) For the 2019 and 2020 MIPS payment years, each Shared Savings Program ACO participant TIN must report data on the Promoting Interoperability performance category separately from the ACO, as specified in §414.1375(b)(2). The ACO participant TIN scores are weighted according to the number of MIPS eligible clinicians in each TIN as a proportion of the total number of MIPS eligible clinicians in the APM Entity group, and then aggregated to determine an APM Entity score for the ACI performance category.

(ii) For the 2019 and 2020 MIPS payment years, for APM Entities in MIPS APMs other than the Shared Savings Program, CMS uses one score for each MIPS eligible clinician in the APM Entity group to derive a single average APM Entity score for the Promoting Interoperability performance category. Beginning with the 2021 MIPS payment year, for APM Entities in MIPS APMs including the Shared Savings Program, CMS uses one score for each MIPS eligible clinician in the APM Entity group to derive a single average APM Entity score for the Promoting Interoperability performance category. The score for each MIPS eligible clinician is the higher of either:

(A) A group score based on the measure data for the Promoting Interoperability performance category reported by a TIN for the MIPS eligible clinician according to MIPS submission and reporting requirements for groups; or

(B) An individual score based on the measure data for the Promoting Interoperability performance category reported by the MIPS eligible clinician according to MIPS submission and reporting requirements for individuals.

(iii) In the event that a MIPS eligible clinician participating in a MIPS APM receives an exception from the Promoting Interoperability performance category reporting requirements, such eligible clinician will be assigned a null score when CMS calculates the APM Entity's Promoting Interoperability performance category score under the APM scoring standard.

(A) If all MIPS eligible clinicians in an APM Entity have been excepted from reporting the Promoting Interoperability performance category, the performance category weight will be reweighted to zero for the APM Entity for that MIPS performance period.

(B) [Reserved]

(h) *APM scoring standard performance category weights.* The performance category weights used to calculate the MIPS final score for an APM Entity group for the APM scoring standard performance period are:

(1) *Quality.* (i) For MIPS APMs that require use of the CMS Web Interface: 50 percent.

(ii) For Other MIPS APMs, 0 percent for 2017, 50 percent beginning in 2018.

(2) *Cost.* 0 percent.

(3) *Improvement activities.* (i) For MIPS APMs that require use of the CMS Web Interface: 20 percent.

(ii) For Other MIPS APMs, 25 percent for 2017, 20 percent beginning in 2018.

(4) *Promoting Interoperability.* (i) For MIPS APMs that require use of the CMS Web Interface: 30 percent.

(ii) For Other MIPS APMs, 25 percent for 2017, 30 percent beginning in 2018.

(5) *Reweighting the MIPS Performance categories for the APM scoring standard.* If CMS determines there are not sufficient measures or activities applicable and available to MIPS eligible clinicians, CMS will assign weights as follows:

(i) If CMS reweights the quality performance category to 0 percent:

(A) In 2017, the improvement activities performance category is reweighted to 25 percent and the Promoting Interoperability performance category is reweighted to 75 percent; and

(B) Beginning in 2018, the Promoting Interoperability performance category is reweighted to 75 percent and the improvement activities performance category is reweighted to 25 percent.

(ii) If CMS reweights the Promoting Interoperability performance category to zero percent:

(A) In 2017, the quality performance category is reweighted to 75 percent and the improvement activities performance category will remain at 25 percent.

(B) Beginning in 2018, the quality performance category is reweighted to 80 percent and the improvement activities performance category will remain at 20 percent.

(i) *Total APM Entity Score.* CMS scores each performance category and then multiplies each performance category score by the applicable performance category weight. CMS then calculates the sum of each weighted performance category score and then applies all applicable adjustments. APM Entities will receive MIPS bonuses applied to the final score as set forth in § 414.1380(b).

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53953, Nov. 16, 2017; 83 FR 23610, May 22, 2018; 83 FR 60080, Nov. 23, 2018]

§ 414.1375 Promoting Interoperability (PI) performance category.

(a) *Final score.* Unless a different scoring weight is assigned by CMS under sections 1848(o)(2)(D), 1848(q)(5)(E)(ii), or 1848(q)(5)(F) of the Act, performance in the Promoting Interoperability performance category comprises 25 percent of a MIPS eligible clinician's final score for each MIPS payment year.

(b) *Reporting for the Promoting Interoperability performance category.* To earn a performance category score for the Promoting Interoperability performance category for inclusion in the final score, a MIPS eligible clinician must:

(1) *CEHRT.* Use CEHRT as defined at § 414.1305 for the performance period;

(2) *Report MIPS—Promoting Interoperability objectives and measures.* Report on the objectives and associated measures as specified by CMS for the Promoting Interoperability performance category for the performance period as follows:

(i) For the 2019 and 2020 MIPS payment years: For each base score measure, as applicable, report the numerator (of at least one) and denominator, or yes/no statement, or claim an exclusion for each measure that includes an option for an exclusion; and

(ii) For the 2021 and 2022 MIPS payment years:

(A) Report that the MIPS eligible clinician completed the actions included in the Security Risk Analysis measure during the year in which the performance period occurs; and

(B) For each required measure, as applicable, report the numerator (of at least one) and denominator, or yes/no statement, or an exclusion for each measure that includes an option for an exclusion.

(3) *Support information exchange and the prevention of health information blocking, and engage in activities related to supporting providers with the performance of CEHRT.* (i) Supporting providers with the performance of CEHRT (SPPC). To engage in activities related to supporting providers with the performance of CEHRT, the MIPS eligible clinician—

(A) Must attest that he or she:

(*1*) Acknowledges the requirement to cooperate in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received; and

(*2*) If requested, cooperated in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the MIPS eligible clinician in the field.

(B) Optionally, may also attest that he or she:

(*1*) Acknowledges the option to cooperate in good faith with ONC–ACB surveillance of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC–ACB surveillance is received; and

(*2*) If requested, cooperated in good faith with ONC–ACB surveillance of his or her health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the MIPS eligible clinician in the field.

(ii) *Support for health information exchange and the prevention of information blocking.* The MIPS eligible clinician must attest to CMS that he or she—

(A) Did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.

(B) Implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times—

(*1*) Connected in accordance with applicable law;

(*2*) Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170;

(*3*) Implemented in a manner that allowed for timely access by patients to their electronic health information; and

(*4*) Implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated providers, and with disparate certified EHR technology and health IT vendors.

(C) Responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53955, Nov. 16, 2017; 83 FR 60080, Nov. 23, 2018]

§414.1380 Scoring.

(a) *General.* MIPS eligible clinicians are scored under MIPS based on their performance on measures and activities in four performance categories. MIPS eligible clinicians are scored against performance standards for each performance category and receive a final score, composed of their performance category scores, and calculated according to the final score methodology.

(1) *Performance standards.* (i) For the quality performance category, measures are scored between zero and 10 measure achievement points. Performance is measured against benchmarks. Measure bonus points are available for submitting high-priority measures, submitting measures using end-to-end electronic reporting, and in small practices that submit data on at least 1 quality measure. Beginning with the 2020 MIPS payment year, improvement scoring is available in the quality performance category.

(ii) For the cost performance category, measures are scored between 1 and 10 points. Performance is measured against a benchmark. Starting with the 2024 MIPS payment year, improvement scoring is available in the cost performance category.

(iii) For the improvement activities performance category, each improvement activity is assigned a certain number of points. The points for all submitted activities are summed and scored against a total potential performance category score of 40 points.

(iv) For the Promoting Interoperability performance category, each measure is scored against a maximum number of points. The points for all submitted measures are summed and scored against a total potential performance category score of 100 points.

(2) [Reserved]

(b) *Performance categories.* MIPS eligible clinicians are scored under MIPS in four performance categories.

(1) *Quality performance category.* (i) *Measure achievement points.* For the 2019, 2020, and 2021 MIPS payment years, MIPS eligible clinicians receive between 3 and 10 measure achievement points (including partial points) for each measure required under §414.1335 on which data is submitted in accordance with §414.1325 that has a benchmark at paragraph (b)(1)(ii) of this section, meets the case minimum requirement at paragraph (b)(1)(iii) of this section, and meets the data completeness requirement at §414.1340. The number of measure achievement points received for each such measure is determined based on the applicable benchmark decile category and the percentile distribution. MIPS eligible clinicians receive zero measure achievement points for each measure required

under § 414.1335 on which no data is submitted in accordance with § 414.1325. MIPS eligible clinicians that submit data in accordance with § 414.1325 on a greater number of measures than required under § 414.1335 are scored only on the required measures with the greatest number of measure achievement points. Beginning with the 2021 MIPS payment year, MIPS eligible clinicians that submit data in accordance with § 414.1325 on a single measure via multiple collection types are scored only on the data submission with the greatest number of measure achievement points.

(A) *Lack of benchmark or case minimum.* (*1*) Except as provided in paragraph (b)(1)(i)(A)(*2*) of this section, for the 2019, 2020, and 2021 MIPS payment years, MIPS eligible clinicians receive 3 measure achievement points for each submitted measure that meets the data completeness requirement, but does not have a benchmark or meet the case minimum requirement.

(*2*) The following measures are excluded from a MIPS eligible clinician's total measure achievement points and total available measure achievement points:

(*i*) Each submitted CMS Web Interface-based measure that meets the data completeness requirement, but does not have a benchmark or meet the case minimum requirement, or is redesignated as pay-for-reporting for all Shared Savings Program accountable care organizations by the Shared Savings Program; and

(*ii*) Each administrative claims-based measure that does not have a benchmark or meet the case minimum requirement.

(B) *Lack of complete data.* (*1*) Except as provided in paragraph (b)(1)(i)(B)(*2*) of this section, for each submitted measure that does not meet the data completeness requirement:

(*i*) For the 2019 MIPS payment year, MIPS eligible clinicians receive 3 measure achievement points;

(*ii*) For the 2020 and 2021 MIPS payment years, MIPS eligible clinicians other than small practices receive 1 measure achievement point, and small practices receive 3 measure achievement points; and

(*iii*) Beginning with the 2022 MIPS payment year, MIPS eligible clinicians other than small practices receive zero measure achievement points, and small practices receive 3 measure achievement points.

(*2*) MIPS eligible clinicians receive zero measure achievement points for each submitted CMS Web Interface-based measure that does not meet the data completeness requirement.

(ii) *Benchmarks.* Benchmarks will be based on collection type, from all available sources, including MIPS eligible clinicians and APMs, to the extent feasible, during the applicable baseline or performance period.

(A) Each benchmark must have a minimum of 20 individual clinicians or groups who reported the measure meeting the case minimum requirement at paragraph (b)(1)(iii) of this section and the data completeness requirement at § 414.1340 and having a performance rate that is greater than zero.

(B) CMS Web Interface collection type uses benchmarks from the corresponding reporting year of the Shared Savings Program.

(iii) *Minimum case requirements.* Except for the all-cause hospital readmission measure, the minimum case requirement is 20 cases. For the all-cause hospital readmission measure, the minimum case requirement is 200 cases.

(iv) *Topped out measures.* CMS will identify topped out measures in the benchmarks published for each Quality Payment Program year.

(A) For the 2020 MIPS payment year, each topped out measure specified by CMS through rulemaking receives no more than 7 measure achievement points, provided that the benchmark for the applicable collection type is identified as topped out in the benchmarks published for the 2018 MIPS performance period.

(B) Beginning with the 2021 MIPS payment year, each measure (except for measures in the CMS Web Interface) for which the benchmark for the applicable collection type is identified as topped out for 2 or more consecutive years receives no more than 7 measure achievement points in the second consecutive year it is identified as topped out, and beyond.

(v) *Measure bonus points.* MIPS eligible clinicians receive measure bonus points for the following measures, except as otherwise required under §414.1335, regardless of whether the measure is included in the MIPS eligible clinician's total measure achievement points.

(A) *High priority measures.* Subject to paragraph (b)(1)(v)(A)(*1*) of this section, MIPS eligible clinicians receive 2 measure bonus points for each outcome and patient experience measure and 1 measure bonus point for each other high priority measure. Beginning with the 2021 MIPS payment year, MIPS eligible clinicians do not receive such measure bonus points for CMS Web Interface measures.

(*1*) *Limitations.* (*i*) Each high priority measure must have a benchmark at paragraph (b)(1)(ii) of this section, meet the case minimum requirement at (b)(1)(iii) of this section, meet the data completeness requirement at §414.1340, and have a performance rate that is greater than zero.

(*ii*) For the 2019, 2020, and 2021 MIPS payment years, the total measure bonus points for high priority measures cannot exceed 10 percent of the total available measure achievement points.

(*iii*) Beginning with the 2021 MIPS payment year, MIPS eligible clinicians that collect data in accordance with §414.1325 on a single measure via multiple collection types receive measure bonus points only once.

(B) *End-to-end electronic reporting.* Subject to paragraph (b)(1)(v)(B)(*1*) of this section, MIPS eligible clinicians receive 1 measure bonus point for each measure (except claims-based measures) submitted with end-to-end electronic reporting for a quality measure under certain criteria determined by the Secretary.

(*1*) *Limitations.* (*i*) For the 2019, 2020, and 2021 MIPS payment years, the total measure bonus points for measures submitted with end-to-end electronic reporting cannot exceed 10 percent of the total available measure achievement points.

(*ii*) Beginning with the 2021 MIPS payment year, MIPS eligible clinicians that collect data in accordance with §414.1325 on a single measure via multiple collection types receive measure bonus points only once.

(C) *Small practices.* Beginning with the 2021 MIPS payment year, MIPS eligible clinicians in small practices receive 6 measure bonus points if they submit data to MIPS on at least 1 quality measure.

(vi) *Improvement scoring.* Improvement scoring is available to MIPS eligible clinicians that demonstrate improvement in performance in the current MIPS performance period compared to performance in the performance period immediately prior to the current MIPS performance period based on measure achievement points.

(A) Improvement scoring is available when the data sufficiency standard is met, which means when data are available and a MIPS eligible clinician has a quality performance category achievement percent score for the previous performance period and the current performance period.

(*1*) Data must be comparable to meet the requirement of data sufficiency which means that the quality performance category achievement percent score is available for the current performance period and the previous performance period and quality performance category achievement percent scores can be compared.

(*2*) Quality performance category achievement percent scores are comparable when submissions are received from the same identifier for two consecutive performance periods.

(*3*) If the identifier is not the same for 2 consecutive performance periods, then for individual submissions, the comparable quality performance category achievement percent score is the highest available quality performance category achievement percent score associated with the final score from the prior performance period that will be used for payment for the individual. For group, virtual group, and APM Entity submissions, the comparable quality performance category achievement percent score is the average of the quality performance category achievement percent score associated with the final score from the prior performance period that will be used for payment for each of the individuals in the group.

(*4*) Improvement scoring is not available for clinicians who were scored under facility-based measurement in the performance period immediately prior to the current MIPS performance period.

(B) The improvement percent score may not total more than 10 percentage points.

(C) The improvement percent score is assessed at the performance category level for the quality performance category and included in the calculation of the quality performance category percent score as described in paragraph (b)(1)(vii) of this section.

(*1*) The improvement percent score is awarded based on the rate of increase in the quality performance category achievement percent score of MIPS eligible clinicians from the previous performance period to the current performance period.

(*2*) An improvement percent score is calculated by dividing the increase in the quality performance category achievement percent score from the prior performance period to the current performance period by the prior performance period quality performance category achievement percent score multiplied by 10 percent.

(*3*) An improvement percent score cannot be lower than zero percentage points.

(*4*) For the 2020 and 2021 MIPS payment year, we will assume a quality performance category achievement percent score of 30 percent if a MIPS eligible clinician earned a quality performance category score less than or equal to 30 percent in the previous year.

(*5*) The improvement percent score is zero if the MIPS eligible clinician did not fully participate in the quality performance category for the current performance period.

(D) For the purpose of improvement scoring methodology, the term ''quality performance category achievement percent score'' means the total measure achievement points divided by the total available measure achievement points, without consideration of measure bonus points or improvement percent score.

(E) For the purpose of improvement scoring methodology, the term ''improvement percent score'' means the score that represents improvement for the purposes of calculating the quality performance category percent score as described in paragraph (b)(1)(vii) of this section.

(F) For the purpose of improvement scoring methodology, the term ''fully participate'' means the MIPS eligible clinician met all requirements in §§ 414.1335 and 414.1340.

(vii) *Quality performance category score.* A MIPS eligible clinician's quality performance category percent score is the sum of all the measure achievement points assigned for the measures required for the quality performance category criteria plus the measure bonus points in paragraph (b)(1)(v) of this section. The sum is divided by the sum of total available measure achievement points. The improvement percent score in paragraph (b)(1)(vi) of this section is added to that result. The quality performance category percent score cannot exceed 100 percentage points.

(A) Beginning with the 2021 MIPS payment year, for each measure that a MIPS eligible clinician submits that is significantly impacted by clinical guideline changes or other changes that CMS believes may result in patient harm or misleading results, the total available measure achievement points are reduced by 10 points.

(B) Beginning with the 2021 MIPS payment year, for groups that submit 5 or fewer measures and register for the CAHPS for MIPS survey but do not meet the minimum beneficiary sampling requirements, the total available measure achievement points are reduced by 10 points.

(viii) *ICD–10 updates.* Beginning with the 2018 MIPS performance period, measures significantly impacted by ICD–10 updates, as determined by CMS, will be assessed based only on the first 9 months of the 12-month performance period. For purposes of this paragraph (b)(1)(viii), CMS will make a determination as to whether a measure is significantly impacted by ICD–10 coding changes during the performance period. CMS will publish on the CMS website which measures require a 9-month assessment process by October

1st of the performance period if technically feasible, but by no later than the beginning of the data submission period at §414.1325(f)(1).

(2) *Cost performance category*. For each cost measure attributed to a MIPS eligible clinician, the clinician receives one to ten achievement points based on the clinician's performance on the measure during the performance period compared to the measure's benchmark. Achievement points are awarded based on which benchmark decile range the MIPS eligible clinician's performance on the measure is between. CMS assigns partial points based on the percentile distribution.

(i) Cost measure benchmarks are determined by CMS based on cost measure performance during the performance period. At least 20 MIPS eligible clinicians or groups must meet the minimum case volume specified under §414.1350(c) for a cost measure in order for a benchmark to be determined for the measure. If a benchmark is not determined for a cost measure, the measure will not be scored.

(ii) A MIPS eligible clinician must meet the minimum case volume specified under §414.1350(c) to be scored on a cost measure.

(iii) The cost performance category percent score is the sum of the following, not to exceed 100 percent:

(A) The total number of achievement points earned by the MIPS eligible clinician divided by the total number of available achievement points; and

(B) The cost improvement score, as determined under paragraph (b)(2)(iv) of this section.

(iv) The cost improvement score is determined for a MIPS eligible clinician that demonstrates improvement in performance in the current MIPS performance period compared to their performance in the immediately preceding MIPS performance period.

(A) The cost improvement score is determined at the measure level for the cost performance category.

(B) The cost improvement score is calculated only when data sufficient to measure improvement is available. Sufficient data is available when a MIPS eligible clinician or group participates in MIPS using the same identifier in 2 consecutive performance periods and is scored on the same cost measure(s) for 2 consecutive performance periods. If the cost improvement score cannot be calculated because sufficient data is not available, then the cost improvement score is zero.

(C) The cost improvement score is determined by comparing the number of measures with a statistically significant change (improvement or decline) in performance; a change is determined to be significant based on application of a t-test. The number of cost measures with a significant decline is subtracted from the number of cost measures with a significant improvement, with the result divided by the number of cost measures for which the MIPS eligible clinician or group was scored for 2 consecutive performance periods. The resulting fraction is then multiplied by the maximum cost improvement score.

(D) The cost improvement score cannot be lower than zero percentage points.

(E) The maximum cost improvement score for the 2020, 2021, 2022, and 2023 MIPS payment years is zero percentage points.

(v) A cost performance category percent score is not calculated if a MIPS eligible clinician or group is not attributed any cost measures for the performance period because the clinician or group has not met the minimum case volume specified by CMS for any of the cost measures or a benchmark has not been created for any of the cost measures that would otherwise be attributed to the clinician or group.

(3) *Improvement activities performance category*. Subject to paragraphs (b)(3)(i) and (ii) of this section, the improvement activities performance category score equals the total points for all submitted improvement activities divided by 40 points, multiplied by 100 percent. MIPS eligible clinicians (except for non-patient facing MIPS eligible clinicians, small practices, and practices located in rural areas and geographic HPSAs) receive 10 points for each medium-weighted improvement activity and 20 points for each high-weighted improvement activity required under §414.1360 on which data is submitted in accordance with §414.1325.

Non-patient facing MIPS eligible clinicians, small practices, and practices located in rural areas and geographic HPSAs receive 20 points for each medium-weighted improvement activity and 40 points for each high-weighted improvement activity required under § 414.1360 on which data is submitted in accordance with § 414.1325.

(i) For MIPS eligible clinicians participating in APMs, the improvement activities performance category score is at least 50 percent.

(ii) For MIPS eligible clinicians in a practice that is certified or recognized as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, the improvement activities performance category score is 100 percent. For the 2019 MIPS payment year, at least one practice site within a group's TIN must be certified or recognized as a patient-centered medical home or comparable specialty practice. For the 2020 MIPS payment year and future years, at least 50 percent of the practice sites within a group's TIN must be recognized as a patient-centered medical home or comparable specialty practice. MIPS eligible clinicians that wish to claim this status for purposes of receiving full credit in the improvement activities performance category must attest to their status as a patient-centered medical home or comparable specialty practice in order to receive this credit. A practice is certified or recognized as a patient-centered medical home if it meets any of the following criteria:

(A) The practice has received accreditation from one of four accreditation organizations that are nationally recognized;

(*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.

(*5*) Provide enhanced access.

(4) *Promoting Interoperability performance category.* (i) For the 2019 and 2020 MIPS payment years, a MIPS eligible clinician's Promoting Interoperability performance category score equals the sum of the base score, performance score, and any applicable bonus scores, not to exceed 100 percentage points. A MIPS eligible clinician cannot earn a performance score or bonus score unless they have earned a base score.

(A) A MIPS eligible clinician earns a base score by reporting for each base score measure, as applicable: The numerator (of at least one) and denominator, or a yes/no statement, or an exclusion.

(B) A MIPS eligible clinician earns a performance score by reporting on the performance score measures specified by CMS. A MIPS eligible clinician may earn up to 10 or 20 percentage points as specified by CMS for each performance score measure reported.

(C) A MIPS eligible clinician may earn the following bonus scores:

(*1*) A bonus score of 5 percentage points for reporting to one or more additional public health agencies or clinical data registries.

(*2*) A bonus score of 10 percentage points for attesting to completing one or more improvement activities specified by CMS using CEHRT.

(*3*) For the 2020 MIPS payment year, a bonus score of 10 percentage points for submitting data for the measures for the base score and the performance score generated solely from CEHRT as defined in § 414.1305 for 2019 and subsequent years.

(ii) For the 2021 and 2022 MIPS payment years, a MIPS eligible clinician's Promoting Interoperability performance category score equals the sum of the scores for each of the six required measures and any applicable bonus scores, not to exceed 100 points.

(A) A MIPS eligible clinician earns a score for each measure by reporting, as applicable: the numerator (of at least one) and denominator, or a yes/no statement. If an exclusion is reported for a measure, the points available for that measure are redistributed to another measure(s).

(B) Each required measure is worth 10, 20, or 40 points, as specified by CMS.

(C) Each optional measure is worth five bonus points.

(c) *Final score calculation.* Each MIPS eligible clinician receives a final score of 0 to 100 points for a performance period for a MIPS payment year calculated as follows. If a MIPS eligible clinician is scored on fewer than 2 performance categories, he or she receives a final score equal to the performance threshold.

For the 2019 MIPS payment year:

Final score = [(quality performance category percent score × quality performance category weight) + (cost performance category percent score × cost performance category weight) + (improvement activities performance category score × improvement activities performance category weight) + (Promoting Interoperability performance category score × Promoting Interoperability performance category weight)], not to exceed 100 points.

For the 2020 MIPS payment year:

Final score = [(quality performance category percent score × quality performance category weight) + (cost performance category percent score × cost performance category weight) + (improvement activities performance category score × improvement activities performance category weight) + (Promoting Interoperability performance category score × Promoting Interoperability performance category weight)] × 100 + [the complex patient bonus + the small practice bonus], not to exceed 100 points.

Beginning with the 2021 MIPS payment year:

Final score = [(quality performance category percent score × quality performance category weight) + (cost performance category percent score × cost performance category weight) + (improvement activities performance category score × improvement activities performance category weight) + (Promoting Interoperability performance category score × Promoting Interoperability performance category weight)] × 100 + the complex patient bonus, not to exceed 100 points.

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(1) *Performance category weights.* The weights of the performance categories in the final score are as follows, unless a different scoring weight is assigned under paragraph (c)(2) of this section:

(i) Quality performance category weight is defined under §414.1330(b).

(ii) Cost performance category weight is defined under §414.1350(d).

(iii) Improvement activities performance category weight is defined under §414.1355(b).

(iv) Promoting Interoperability performance category weight is defined under §414.1375(a).

(2) *Reweighting the performance categories.* (i) In accordance with paragraph (c)(2)(ii) of this section, a scoring weight different from the weights specified in paragraph (c)(1) of this section will be assigned to a performance category, and its weight as specified in paragraph (c)(1) of this section will be redistributed to another performance category or categories, in the following circumstances:

(A) CMS determines based on the following circumstances that there are not sufficient measures and activities applicable and available under section 1848(q)(5)(F) of the Act.

(*1*) For the quality performance category, CMS cannot calculate a score for the MIPS eligible clinician because there is not at least one quality measure applicable and available to the clinician.

(*2*) For the cost performance category, CMS cannot reliably calculate a score for the cost measures that adequately captures and reflects the performance of the MIPS eligible clinician.

(*3*) Beginning with the 2021 MIPS payment year, for the quality, cost, improvement activities, and Promoting Interoperability performance categories, the MIPS eligible clinician joins an existing practice during the final 3 months of the performance period year that is not participating in MIPS as a group or joins a practice that is newly formed during the final 3 months of the performance period year.

(*4*) For the Promoting Interoperability performance category beginning with the 2021 MIPS payment year, the MIPS eligible clinician is a physical therapist, occupational therapist, clinical psychologist, qualified audiologist, qualified speech-language pathologist, or a registered dietitian or nutrition professional. In the event that a MIPS eligible clinician submits data for the Promoting Interoperability performance category, the scoring weight specified in paragraph (c)(1) of this section will be applied and its weight will not be redistributed.

(*5*) For the Promoting Interoperability performance category for the 2019, 2020, and 2021 MIPS payment years, the MIPS eligible clinician is a nurse practitioner, physician assistant, clinical nurse specialist, or certified registered nurse anesthetist. In the event that a MIPS eligible clinician submits data for the Promoting Interoperability performance category, the scoring weight specified in paragraph (c)(1) of this section will be applied and its weight will not be redistributed.

(*6*) Beginning with the 2020 MIPS payment year, for the quality, cost, and improvement activities performance categories, the MIPS eligible clinician demonstrates through an application submitted to CMS that they were subject to extreme and uncontrollable circumstances that prevented the clinician from collecting information that the clinician would submit for a performance category or submitting information that would be used to score a performance category for an extended period of time. Beginning with the 2021 MIPS payment year, in the event that a MIPS eligible clinician submits data for the quality, cost, or improvement activities performance categories, the scoring weight specified in paragraph (c)(1) of this section will be applied and its weight will not be redistributed.

(*7*) For the 2019 MIPS payment year, for the quality and improvement activities performance categories, the MIPS eligible clinician was located in an area affected by extreme and uncontrollable circumstances as identified by CMS. In the event that a MIPS eligible clinician submits data for a performance category, the scoring weight specified in paragraph (c)(1) of this section will be applied and its weight will not be redistributed.

(*8*) Beginning with the 2020 MIPS payment year, for the quality, cost, and improvement activities performance categories, the MIPS eligible clinician was located in an area affected by extreme and uncontrollable circumstances as identified by CMS. In the event that a MIPS eligible clinician submits data for the quality or improvement activities performance categories, the scoring weight specified in paragraph (c)(1) of this section will be applied and its weight will not be redistributed.

(B) Under section 1848(q)(5)(E)(ii) of the Act, CMS estimates that the proportion of MIPS eligible clinicians who are physicians as defined in section 1861(r) of the Act and earn a Promoting Interoperability performance category score of at least 75 percent is 75 percent or greater. The estimation is based on data from the performance period that occurs four years before the MIPS payment year and does not include physicians for whom the Promoting Interoperability performance category is weighted at zero percent.

(C) Under section 1848(o)(2)(D) of the Act, a significant hardship exception or other type of exception is granted to a MIPS eligible clinician based on the following circumstances for the Promoting Interoperability performance category. In the event that a MIPS eligible clinician submits data for the Promoting Interoperability performance category, the scoring weight specified in paragraph (c)(1) of this section

will be applied and its weight will not be redistributed.

(*1*) The MIPS eligible clinician demonstrates through an application submitted to CMS that they lacked sufficient internet access during the performance period, and insurmountable barriers prevented the clinician from obtaining sufficient internet access.

(*2*) The MIPS eligible clinician demonstrates through an application submitted to CMS that they were subject to extreme and uncontrollable circumstances that caused their CEHRT to be unavailable.

(*3*) The MIPS eligible clinician was located in an area affected by extreme and uncontrollable circumstances as identified by CMS.

(*4*) The MIPS eligible clinician demonstrates through an application submitted to CMS that 50 percent or more of their outpatient encounters occurred in practice locations where they had no control over the availability of CEHRT.

(*5*) The MIPS eligible clinician is a non-patient facing MIPS eligible clinician as defined in §414.1305.

(*6*) The MIPS eligible clinician is a hospital-based MIPS eligible clinician as defined in §414.1305.

(*7*) The MIPS eligible clinician is an ASC-based MIPS eligible clinician as defined in §414.1305.

(*8*) Beginning with the 2020 MIPS payment year, the MIPS eligible clinician demonstrates through an application submitted to CMS that their CEHRT was decertified either during the performance period for the MIPS payment year or during the calendar year preceding the performance period for the MIPS payment year, and the MIPS eligible clinician made a good faith effort to adopt and implement another CEHRT in advance of the performance period. In no case may a MIPS eligible clinician be granted this exception for more than 5 years.

(*9*) Beginning with the 2020 MIPS payment year, the MIPS eligible clinician demonstrates through an application submitted to CMS that they are in a small practice as defined in §414.1305, and overwhelming barriers prevent them from complying with the requirements for the Promoting Interoperability performance category.

(ii) A scoring weight different from the weights specified in paragraph (c)(1) of this section will be assigned to a performance category, and its weight as specified in paragraph (c)(1) of this section will be redistributed to another performance category or categories, as follows:

(A) For the 2019 MIPS payment year:

Performance category (%)	Weighting for the 2019 MIPS payment year (%)	Reweight scenario if no promoting interoperability performance category score (%)	Reweight scenario if no quality performance category percent score (%)	Reweight scenario if no improvement activities performance category score (%)
Quality	60	85	0	75
Cost	0	0	0	0
Improvement Activities	15	15	50	0
Promoting Interoperability	25	0	50	25

(B) For the 2020 MIPS payment year:

Reweighting scenario	Quality (%)	Cost (%)	Improvement activities (%)	Promoting interoperability (%)
No Reweighting Needed:				
—Scores for all four performance categories	50	10	15	25
Reweight One Performance Category:				
—No Cost	60	0	15	25
—No Promoting Interoperability	75	10	15	0
—No Quality	0	10	45	45
—No Improvement Activities	65	10	0	25
Reweight Two Performance Categories:				

Reweighting scenario	Quality (%)	Cost (%)	Improvement activities (%)	Promoting interoperability (%)
—No Cost and no Promoting Interoperability	85	0	15	0
—No Cost and no Quality	0	0	50	50
—No Cost and no Improvement Activities	75	0	0	25
—No Promoting Interoperability and no Quality	0	10	90	0
—No Promoting Interoperability and no Improvement Activities	90	10	0	0
—No Quality and no Improvement Activities	0	10	0	90

(C) For the 2021 MIPS payment year:

Reweighting scenario	Quality (%)	Cost (%)	Improvement activities (%)	Promoting interoperability (%)
No Reweighting Needed:				
—Scores for all four performance categories	45	15	15	25
Reweight One Performance Category:				
—No Cost	60	0	15	25
—No Promoting Interoperability	70	15	15	0
—No Quality	0	15	40	45
—No Improvement Activities	60	15	0	25
Reweight Two Performance Categories:				
—No Cost and no Promoting Interoperability	85	0	15	0
—No Cost and no Quality	0	0	50	50
—No Cost and no Improvement Activities	75	0	0	25
—No Promoting Interoperability and no Quality	0	15	85	0
—No Promoting Interoperability and no Improvement Activities	85	15	0	0
—No Quality and no Improvement Activities	0	15	0	85

(iii) For MIPS eligible clinicians submitting data as a group or virtual group, in order for the Promoting Interoperability performance category to be reweighted in accordance with paragraph (c)(2)(ii) of this section, all of the MIPS eligible clinicians in the group must qualify for reweighting based on the circumstances described in paragraph (c)(2)(i) of this section.

(3) *Complex patient bonus.* For the 2020 and 2021 MIPS payment years, provided that a MIPS eligible clinician, group, virtual group or APM entity submits data for at least one MIPS performance category for the applicable performance period for the MIPS payment year, a complex patient bonus will be added to the final score for the MIPS payment year, as follows:

(i) For MIPS eligible clinicians and groups, the complex patient bonus is calculated as follows: [The average HCC risk score assigned to beneficiaries (pursuant to the HCC risk adjustment model established by CMS pursuant to section 1853(a)(1) of the Act) seen by the MIPS eligible clinician or seen by clinicians in a group] + [the dual eligible ratio × 5].

(ii) For APM entities and virtual groups, the complex patient bonus is calculated as follows: [The beneficiary weighted average HCC risk score for all MIPS eligible clinicians, and if technically feasible, TINs for models and virtual groups which rely on complete TIN participation within the APM entity or virtual group, respectively] + [the average dual eligible ratio for all MIPS eligible clinicians, and if technically feasible, TINs for models and virtual groups which rely on complete TIN participation, within the APM entity or virtual group, respectively, × 5].

(iii) The complex patient bonus cannot exceed 5.0.

(4) *Small practice bonus.* A small practice bonus of 5 points will be added to the final score for the 2020 MIPS payment year for MIPS eligible clinicians, groups, virtual groups, and APM Entities that meet the definition of a small practice as defined at § 414.1305 and participate in MIPS by submitting data on at least one performance category in the 2018 MIPS performance period.

(d) *Scoring for APM Entities.* MIPS eligible clinicians in APM Entities that are subject to the APM scoring standard are scored using the methodology under §414.1370.

(e) *Scoring for facility-based measurement.* For the payment in 2021 MIPS payment year and subsequent years and subject to paragraph (e)(6)(vi) of this section, a MIPS eligible clinician or group will be scored under the quality and cost performance categories using the methodology described in this paragraph (e).

(1) *General.* The facility-based measurement scoring standard is the MIPS scoring methodology applicable for MIPS eligible clinicians identified as meeting the requirements in paragraph (e)(2) of this section.

(i) The measures used for facility-based measurement are the measure set finalized for the fiscal year value-based purchasing program for which payment begins during the applicable MIPS performance period.

(ii) Beginning with the 2021 MIPS payment year, the scoring methodology applicable for MIPS eligible clinicians scored with facility-based measurement is the Total Performance Score methodology adopted for the Hospital VBP Program, for the fiscal year for which payment begins during the applicable MIPS performance period.

(2) *Eligibility for facility-based measurement.* MIPS eligible clinicians are eligible for facility-based measurement for a MIPS payment year if they are determined to be facility-based as an individual clinician or as part of a group, as follows:

(i) *Facility-based individual determination.* A MIPS eligible clinician is facility-based if the clinician meets all of the following criteria:

(A) Furnishes 75 percent or more of his or her covered professional services in sites of service identified by the place of service codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, or emergency room setting based on claims for a 12-month segment beginning on October 1 of the calendar year 2 years prior to the applicable performance period and ending on September 30 of the calendar year preceding the performance period with a 30-day claims run out.

(B) Furnishes at least 1 covered professional service in sites of service identified by the place of service codes used in the HIPAA standard transaction as an inpatient hospital, or emergency room setting.

(C) Can be attributed, under the methodology specified in paragraph (e)(5) of this section, to a facility with a value-based purchasing score for the applicable period.

(ii) *Facility-based group determination.* A facility-based group is a group in which 75 percent or more of its eligible clinician NPIs billing under the group's TIN meet the requirements under paragraph (e)(2)(i) of this section.

(3) [Reserved]

(4) *Data submission for facility-based measurement.* There are no data submission requirements for individual clinicians to be scored under facility-based measurement. A group must submit data in the improvement activities or Promoting Interoperability performance categories in order to be scored as a facility-based group.

(5) *Determination of applicable facility score.* (i) A facility-based clinician is scored with facility-based measurement using the score derived from the value-based purchasing score for the facility at which the clinician provided services to the most Medicare beneficiaries during the period the claims are drawn from in paragraph (e)(2) of this section. If there is an equal number of Medicare beneficiaries treated at more than one facility, the value-based purchasing score for the highest scoring facility is used.

(ii) A facility-based group is scored with facility-based measurement using the score derived from the value-based purchasing score for the facility at which the plurality of clinicians identified as facility-based would have had their score determined under paragraph (e)(5)(i) of this section.

(6) *MIPS performance category scoring under the facility-based measurement scoring standard*—(i) *Measures.* The quality and cost measures are those adopted under the value-based purchasing program of the facility for the year described in paragraph (e)(1)(i) of this section.

(ii) *Benchmarks.* The benchmarks are those adopted under the value-based purchasing program of the facility program for the year described in paragraph (e)(1) of this section.

(iii) *Performance period.* The performance period for facility-based measurement is the performance period for the measures adopted under the value-based purchasing program of the facility program for the year described in paragraph (e)(1) of this section.

(iv) *Quality.* The quality performance category percent score is established by determining the percentile performance of the facility in the value-based purchasing program for the specified year as described in paragraph (e)(1) of this section and awarding a score associated with that same percentile performance in the MIPS quality performance category percent score for those MIPS-eligible clinicians who are not eligible to be scored using facility-based measurement for the MIPS payment year. A clinician or group receiving a facility-based performance score will not earn improvement points based on prior performance in the MIPS quality performance category

(v) *Cost.* The cost performance category percent score is established by determining the percentile performance of the facility in the value-based purchasing program for the specified year as described in paragraph (e)(1) of this section and awarding a score associated with that same percentile performance in the MIPS cost performance category percent score for those MIPS eligible clinicians who are not eligible to be scored using facility-based measurement for the MIPS payment year. A clinician or group receiving a facility-based performance score will not earn improvement points based on prior performance in the MIPS cost category.

(A) *Other cost measures.* MIPS eligible clinicians who are scored under facility-based measurement are not scored on cost measures described in paragraph (b)(2) of this section.

(B) [Reserved]

(vi) *Use of score from facility-based measurement.* The MIPS quality and cost performance category scores will be based on the facility-based measurement scoring methodology described in paragraph (e)(6) of this section unless a clinician or group receives a higher combined MIPS quality and cost performance category score through another MIPS submission.

[83 FR 60081, Nov. 23, 2018]

§ 414.1385 Targeted review and review limitations.

(a) *Targeted review.* MIPS eligible clinicians or groups may request a targeted review of the calculation of the MIPS payment adjustment factor under section 1848(q)(6)(A) of the Act and, as applicable, the calculation of the additional MIPS payment adjustment factor under section 1848(q)(6)(C) of the Act applicable to such MIPS eligible clinician or group for a year. The process for targeted reviews is:

(1) MIPS eligible clinicians and groups have a 60-day period to submit a request for targeted review, which begins on the day CMS makes available the MIPS payment adjustment factor, and if applicable the additional MIPS payment adjustment factor, for the MIPS payment year and ends on September 30 of the year prior to the MIPS payment year or a later date specified by CMS.

(2) CMS will respond to each request for targeted review timely submitted and determine whether a targeted review is warranted.

(3) The MIPS eligible clinician or group may include additional information in support of their request for targeted review at the time the request is submitted. If CMS requests additional information from the MIPS eligible clinician or group, it must be provided and received by CMS within 30 days of the request. Non-responsiveness to the request for additional information may result in the closure of the targeted review request, although the MIPS eligible clinician or group may submit another request for targeted review before the deadline.

(4) Decisions based on the targeted review are final, and there is no further review or appeal.

(b) *Limitations on review.* Except as specified in paragraph (a)(4) of this section, there is no administrative or judicial review under section 1869 or 1879 of the Act, or otherwise of—

(1) The methodology used to determine the amount of the MIPS payment adjustment factor and the amount of the additional MIPS payment adjustment factor and the determination of such amounts;

(2) The establishment of the performance standards and the performance period;

(3) The identification of measures and activities specified for a MIPS performance category and information made public or posted on the Physician Compare Internet Web site of the CMS; and

(4) The methodology developed that is used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.

§414.1390 Data validation and auditing.

(a) *General.* CMS will selectively audit MIPS eligible clinicians and groups on a yearly basis. If a MIPS eligible clinician or group is selected for audit, the MIPS eligible clinician or group will be required to do the following in accordance with applicable law and timelines CMS establishes:

(1) Comply with data sharing requests, providing all data as requested by CMS or our designated entity. All data must be shared with CMS or our designated entity within 45 days of the data sharing request, or an alternate timeframe that is agreed to by CMS and the MIPS eligible clinician or group. Data will be submitted via email, facsimile, or an electronic method via a secure Web site maintained by CMS.

(2) Provide substantive, primary source documents as requested. These documents may include: Copies of claims, medical records for applicable patients, or other resources used in the data calculations for MIPS measures, objectives, and activities. Primary source documentation also may include verification of records for Medicare and non-Medicare beneficiaries where applicable.

(b) *Certification.* All MIPS eligible clinicians and groups that submit data and information to CMS for purposes of MIPS must certify to the best of their knowledge that the data submitted to CMS is true, accurate, and complete. Such certification must accompany the submission and be made at the time of submission.

(c) *Reopening.* CMS may reopen and revise a MIPS payment adjustment in accordance with the rules set forth at §§405.980 through 405.986 of this chapter.

(d) *Record retention.* All MIPS eligible clinicians and groups that submit data and information to CMS for purposes of MIPS must retain such data and information for 6 years from the end of the MIPS performance period.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53959, Nov. 16, 2017]

§414.1395 Public reporting.

(a) *Public reporting of eligible clinician and group Quality Payment Program information.* For each program year, CMS posts on Physician Compare, in an easily understandable format, information regarding the performance of eligible clinicians or groups under the Quality Payment Program.

(b) *Maintain existing public reporting standards.* With the exception of data that must be mandatorily reported on Physician Compare, for each program year, CMS relies on established public reporting standards to guide the information available for inclusion on Physician Compare. The public reporting standards require data included on Physician Compare to be statistically valid, reliable, and accurate; comparable across collection types; and meet the reliability threshold. And, to be included on the public facing profile pages, the data must also resonate with website users, as determined by CMS.

(c) *First year measures.* For each program year, CMS does not publicly report any first year measure for the first 2 years, meaning any measure in its first 2 years of use in the quality and cost performance categories. After the first 2 years, CMS reevaluates measures to determine when and if they are suitable for public reporting.

(d) *30-day preview period.* For each program year, CMS provides a 30-day preview period for any clinician or group with Quality Payment Program

data before the data are publicly reported on Physician Compare.

[82 FR 53959, Nov. 16, 2017, as amended at 83 FR 60087, Nov. 23, 2018]

§ 414.1400 Third party intermediaries.

(a) *General.* (1) MIPS data may be submitted on behalf of a MIPS eligible clinician, group, or virtual group by any of the following third party intermediaries:

(i) A QCDR;

(ii) A qualified registry;

(iii) A health IT vendor; or

(iv) A CMS-approved survey vendor.

(2) QCDRs, qualified registries, and health IT vendors may submit MIPS data for any of the following MIPS performance categories:

(i) Quality, except for data on the CAHPS for MIPS survey;

(ii) Improvement activities; or

(iii) Promoting Interoperability, if the MIPS eligible clinician, group, or virtual group is using CEHRT.

(3) CMS-approved survey vendors may submit data on the CAHPS for MIPS survey for the MIPS quality performance category.

(4) To be approved as a third party intermediary, an entity must agree to meet the applicable requirements of this section, including, but not limited to, the following:

(i) A third party intermediary's principle place of business and retention of any data must be based in the U.S.

(ii) If the data is derived from CEHRT, a QCDR, qualified registry, or health IT vendor must be able to indicate its data source.

(iii) All data must be submitted in the form and manner specified by CMS.

(iv) If the clinician chooses to opt-in in accordance with § 414.1310, the third party intermediary must be able to transmit that decision to CMS.

(5) All data submitted to CMS by a third party intermediary on behalf of a MIPS eligible clinician, group or virtual group must be certified by the third party intermediary as true, accurate, and complete to the best of its knowledge. Such certification must be made in a form and manner and at such time as specified by CMS.

(b) *QCDR approval criteria*—(1) *QCDR self-nomination.* For the 2020 and 2021 MIPS payment years, entities seeking to qualify as a QCDR must self-nominate September 1 until November 1 of the CY preceding the applicable performance period. For the 2022 MIPS payment year and future years, entities seeking to qualify as a QCDR must self-nominate during a 60-day period during the CY preceding the applicable performance period (beginning no earlier than July 1 and ending no later than September 1). Entities seeking to qualify as a QCDR for a performance period must provide all information required by CMS at the time of self-nomination and must provide any additional information requested by CMS during the review process. For the 2021 MIPS payment year and future years, existing QCDRs that are in good standing may attest that certain aspects of their previous year's approved self-nomination have not changed and will be used for the applicable performance period.

(2) *Establishment of a QCDR entity.* (i) Beginning with the 2022 MIPS Payment Year, the QCDR must have at least 25 participants by January 1 of the year prior to the applicable performance period.

(ii) If the entity uses an external organization for purposes of data collection, calculation, or transmission, it must have a signed, written agreement with the external organization that specifically details the responsibilities of the entity and the external organization. The written agreement must be effective as of September 1 of the year preceding the applicable performance period.

(3) *QCDR measures for the quality performance category.* (i) For purposes of QCDRs submitting data for the MIPS quality performance category, CMS considers the following types of quality measures to be QCDR measures:

(A) Measures that are not included in the MIPS final list of quality measures described in § 414.1330(a)(1) for the applicable MIPS payment year; and

(B) Measures that are included in the MIPS final list of quality measures described in § 414.1330(a)(1) for the applicable MIPS payment year, but have undergone substantive changes, as determined by CMS.

(ii) For the 2020 MIPS payment year and future years, an entity seeking to

become a QCDR must submit specifications for each measure, activity, and objective that the entity intends to submit to for MIPS (including the information described in paragraphs (b)(3)(ii)(A) and (B) of this section) at the time of self-nomination. In addition, no later than 15 calendar days following CMS approval of any QCDR measure specifications, the entity must publicly post the measure specifications for each QCDR measure (including the CMS-assigned QCDR measure ID) and provide CMS with a link to where this information is posted.

(A) For QCDR measures, the entity must submit the measure specifications for each QCDR measure, including: Name/title of measures, NQF number (if NQF-endorsed), descriptions of the denominator, numerator, and when applicable, denominator exceptions, denominator exclusions, risk adjustment variables, and risk adjustment algorithms.

(B) For MIPS quality measures, the entity must submit the MIPS measure IDs and specialty-specific measure sets, as applicable.

(iii) A QCDR must include the CMS-assigned QCDR measure ID when submitting data on any QCDR measure to CMS.

(c) *Qualified registry approval criteria*—(1) *Qualified registry self-nomination.* For the 2020 and 2021 MIPS payment years, entities seeking to qualify as a qualified registry must self-nominate from September 1 until November 1 of the CY preceding the applicable performance period. For the 2022 MIPS payment year and future years, entities seeking to qualify as a qualified registry must self-nominate during a 60-day period during the CY preceding the applicable performance period (beginning no earlier than July 1 and ending no later than September 1). Entities seeking to qualify as a qualified registry for a performance period must provide all information required by CMS at the time of self-nomination and must provide any additional information requested by CMS during the review process. For the 2021 MIPS payment year and future years, existing qualified registries that are in good standing may attest that certain aspects of their previous year's approved self-nomination have not changed and will be used for the applicable performance period.

(2) *Establishment of a qualified registry entity.* Beginning with the 2022 MIPS Payment Year, the qualified registry must have at least 25 participants by January 1 of the year prior to the applicable performance period.

(d) *Health IT vendor approval criteria.* Health IT vendors must meet the criteria specified at paragraph (a)(4) of this section.

(e) *CMS-approved survey vendor approval criteria.* Entities seeking to be a CMS-approved survey vendor for any MIPS performance period must submit a survey vendor application to CMS in a form and manner specified by CMS for each MIPS performance period for which it wishes to transmit such data. The application and any supplemental information requested by CMS must be submitted by deadlines specified by CMS. For an entity to be a CMS-approved survey vendor, it must meet the following criteria:

(1) The entity must have sufficient experience, capability, and capacity to accurately report CAHPS data, including:

(i) At least 3 years of experience administering mixed-mode surveys (that is, surveys that employ multiple modes to collect date), including mail survey administration followed by survey administration via Computer Assisted Telephone Interview (CATI);

(ii) At least 3 years of experience administering surveys to a Medicare population;

(iii) At least 3 years of experience administering CAHPS surveys within the past 5 years;

(iv) Experience administering surveys in English and at least one other language for which a translation of the CAHPS for MIPS survey is available;

(v) Use equipment, software, computer programs, systems, and facilities that can verify addresses and phone numbers of sampled beneficiaries, monitor interviewers, collect data via CATI, electronically administer the survey and schedule call-backs to beneficiaries at varying times of the day and week, track fielded surveys, assign final disposition codes to reflect the outcome of data collection of each

sampled case, and track cases from mail surveys through telephone follow-up activities; and

(vi) Employment of a program manager, information systems specialist, call center supervisor and mail center supervisor to administer the survey.

(2) The entity has certified that it has the ability to maintain and transmit quality data in a manner that preserves the security and integrity of the data.

(3) The entity has successfully completed, and has required its subcontractors to successfully complete, vendor training(s) administered by CMS or its contractors.

(4) The entity has submitted a quality assurance plan and other materials relevant to survey administration, as determined by CMS, including cover letters, questionnaires and telephone scripts.

(5) The entity has agreed to participate and cooperate, and has required its subcontractors to participate and cooperate, in all oversight activities related to survey administration conducted by CMS or its contractors.

(6) The entity has sent an interim survey data file to CMS that establishes the entity's ability to accurately report CAHPS data.

(f) *Remedial action and termination of third party intermediaries.* (1) If CMS determines that a third party intermediary has ceased to meet one or more of the applicable criteria for approval, or has submitted data that is inaccurate, unusable, or otherwise compromised, CMS may take one or more of the following remedial actions after providing written notice to the third party intermediary:

(i) Require the third party intermediary to submit a corrective action plan (CAP) to CMS to address the identified deficiencies or data issue, including the actions it will take to prevent the deficiencies or data issues from recurring. The CAP must be submitted to CMS by a date specified by CMS.

(ii) Publicly disclose the entity's data error rate on the CMS website until the data error rate falls below 3 percent.

(2) CMS may immediately or with advance notice terminate the ability of a third party intermediary to submit MIPS data on behalf of a MIPS eligible clinician, group, or virtual group for one or more of the following reasons:

(i) CMS has grounds to impose remedial action;

(ii) CMS has not received a CAP within the specified time period or the CAP is not accepted by CMS; or

(iii) The third party intermediary fails to correct the deficiencies or data errors by the date specified by CMS.

(3) For purposes of paragraph (f) of this section, CMS may determine that submitted data is inaccurate, unusable, or otherwise compromised if the submitted data:

(i) Includes, without limitation, TIN/NPI mismatches, formatting issues, calculation errors, or data audit discrepancies; and

(ii) Affects more than 3 percent of the total number of MIPS eligible clinicians or group for which data was submitted by the third party intermediary.

(g) *Auditing of entities submitting MIPS data.* Any third party intermediary must comply with the following procedures as a condition of its qualification and approval to participate in MIPS as a third party intermediary.

(1) The entity must make available to CMS the contact information of each MIPS eligible clinician or group on behalf of whom it submits data. The contact information must include, at a minimum, the MIPS eligible clinician or group's practice phone number, address, and, if available, email.

(2) The entity must retain all data submitted to CMS for purposes of MIPS for 6 years from the end of the MIPS performance period.

(3) For the purposes of auditing, CMS may request any records or data retained for the purposes of MIPS for up to 6 years from the end of the MIPS performance period.

[83 FR 60088, Nov. 23, 2018]

§ 414.1405 Payment.

(a) *General.* Each MIPS eligible clinician receives a MIPS payment adjustment factor, and if applicable an additional MIPS payment adjustment factor for exceptional performance, for a MIPS payment year determined by

comparing their final score to the performance threshold and additional performance threshold for the year.

(b) *Performance threshold.* A performance threshold will be specified for each MIPS payment year.

(1) MIPS eligible clinicians with a final score at or above the performance threshold receive a zero or positive MIPS payment adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a final score at the performance threshold and an adjustment factor of the applicable percent is assigned for a final score of 100.

(2) MIPS eligible clinicians with a final score below the performance threshold receive a negative MIPS payment adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a final score at the performance threshold and an adjustment factor of the negative of the applicable percent is assigned for a final score of 0; further, MIPS eligible clinicians with final scores that are equal to or greater than zero, but not greater than one-fourth of the performance threshold, receive a negative MIPS payment adjustment factor that is equal to the negative of the applicable percent.

(3) A scaling factor not to exceed 3.0 may be applied to positive MIPS payment adjustment factors to ensure budget neutrality such that the estimated increase in aggregate allowed charges resulting from the application of the positive MIPS payment adjustment factors for the MIPS payment year equals the estimated decrease in aggregate allowed charges resulting from the application of negative MIPS payment adjustment factors for the MIPS payment year.

(4) The performance threshold for the 2019 MIPS payment year is 3 points.

(5) The performance threshold for the 2020 MIPS payment year is 15 points.

(6) The performance threshold for the 2021 MIPS payment year is 30 points.

(c) *Applicable percent.* For MIPS payment year 2019, 4 percent. For MIPS payment year 2020, 5 percent. For MIPS payment year 2021, 7 percent. For MIPS payment year 2022 and each subsequent MIPS payment year, 9 percent.

(d) *Additional performance threshold.* An additional performance threshold will be specified for each of the MIPS payment years 2019 through 2024.

(1) In addition to the MIPS payment adjustment factor, MIPS eligible clinicians with a final score at or above the additional performance threshold receive an additional MIPS payment adjustment factor for exceptional performance on a linear sliding scale such that an additional adjustment factor of 0.5 percent is assigned for a final score at the additional performance threshold and an additional adjustment factor of 10 percent is assigned for a final score of 100, subject to the application of a scaling factor as determined by CMS, such that the estimated aggregate increase in payments resulting from the application of the additional MIPS payment adjustment factors for the MIPS payment year shall not exceed $500,000,000 for each of the MIPS payment years 2019 through 2024.

(2) [Reserved]

(3) The additional performance threshold for the 2019 MIPS payment year is 70 points.

(4) The additional performance threshold for the 2020 MIPS payment year is 70 points.

(5) The additional performance threshold for the 2021 MIPS payment year is 75 points.

(e) *Application of adjustments to payments.* Except as specified in paragraph (f) of this section, in the case of covered professional services (as defined in section 1848(k)(3)(A) of the Act) furnished by a MIPS eligible clinician during a MIPS payment year beginning with 2019, the amount otherwise paid under Part B with respect to such covered professional services and MIPS eligible clinician for such year, is multiplied by 1, plus the sum of the MIPS payment adjustment factor divided by 100, and as applicable, the additional MIPS payment adjustment factor divided by 100.

(f) *Exception to application of MIPS payment adjustment factors to model-specific payments under section 1115A APMs.* Effective for the 2019 MIPS payment year, the payment adjustment factors specified under paragraph (e) of this section are not applicable to payments

that meet all of the following conditions:

(1) Are made only to participants in a model tested under section 1115A of the Act;

(2) Would otherwise be subject to the requirement to apply the MIPS payment adjustment factors if the payment is made with respect to a MIPS eligible clinician participating in a section 1115A model; and

(3) Either have a specified payment amount or are paid according to a methodology for calculating a model-specific payment that is applied in a consistent manner to all model participants, such that application of the MIPS payment adjustment factors would potentially interfere with CMS's ability to effectively evaluate the impact of the APM.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53960, Nov. 16, 2017; 83 FR 60089, Nov. 23, 2018]

§ 414.1410 Advanced APM determination.

(a) *General.* An APM is an Advanced APM for a payment year if CMS determines that it meets the criteria in § 414.1415 during the QP Performance Period.

(b) *Advanced APM determination process.* CMS determines Advanced APMs in the following manner:

(1) *Advanced APM determination.* (i) No later than January 1, 2017, CMS will post on its Web site a list of all Advanced APMs for the first QP Performance Period.

(ii) CMS updates the Advanced APM list on its Web site at intervals no less than annually.

(iii) CMS will include notice of whether a new APM is an Advanced APM in the first public notice of the new APM.

(2) [Reserved]

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53960, Nov. 16, 2017]

§ 414.1415 Advanced APM criteria.

(a) *Use of certified electronic health record technology (CEHRT)*—(1) *Required use of CEHRT.* To be an Advanced APM, an APM must:

(i) Require at least 50 percent, or for QP Performance Periods beginning in 2019, 75 percent of eligible clinicians in each participating APM Entity group, or for APMs in which hospitals are the APM Entities, each hospital, to use CEHRT to document and communicate clinical care to their patients or health care providers; or

(ii) For QP Performance Periods prior to 2019, for the Shared Savings Program, apply a penalty or reward to an APM Entity based on the degree of the use of CEHRT of the eligible clinicians in the APM Entity.

(b) *Payment based on quality measures.* (1) To be an Advanced APM, an APM must include quality measure performance as a factor when determining payment to participants for covered professional services under the terms of the APM.

(2) At least one of the quality measures upon which an Advanced APM bases the payment in paragraph (b)(1) of this section must have an evidence-based focus, be reliable and valid, and meet at least one of the following criteria:

(i) Used in the MIPS quality performance category as described in § 414.1330;

(ii) Endorsed by a consensus-based entity;

(iii) Developed under section 1848(s) of the Act;

(iv) Submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act; or

(v) Any other quality measures that CMS determines to have an evidence-based focus and to be reliable and valid.

(3) In addition to the quality measure requirements under paragraph (b)(2) of this section, the quality measures upon which an Advanced APM bases the payment in paragraph (b)(1) of this section must include at least one outcome measure. This requirement does not apply if CMS determines that there are no available or applicable outcome measures included in the MIPS quality measures list for the Advanced APM's first QP Performance Period.

(c) *Financial risk.* To be an Advanced APM, except as described in paragraph (c)(6) of this section, an APM must either meet the financial risk standard under paragraph (c)(1) or (2) of this section and the nominal amount standard under paragraph (c)(3) or (4) of this section or be an expanded Medical Home

Model under section 1115A(c) of the Act.

(1) *Generally applicable financial risk standard.* Except for paragraph (c)(2) of this section, to be an Advanced APM, an APM must, based on whether an APM Entity's actual expenditures for which the APM Entity is responsible under the APM exceed expected expenditures during a specified QP Performance Period, do one or more of the following:

(i) Withhold payment for services to the APM Entity or the APM Entity's eligible clinicians;

(ii) Reduce payment rates to the APM Entity or the APM Entity's eligible clinicians; or

(iii) Require the APM Entity to owe payment(s) to CMS.

(2) *Medical Home Model financial risk standard.* The APM Entity participates in a Medical Home Model that, based on the APM Entity's failure to meet or exceed one or more specified performance standards, which may include expected expenditures, does one or more of the following:

(i) Withholds payment for services to the APM Entity or the APM Entity's eligible clinicians;

(ii) Reduces payment rates to the APM Entity or the APM Entity's eligible clinicians;

(iii) Requires the APM Entity to owe payment(s) to CMS; or

(iv) Causes the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.

(3) *Generally applicable nominal amount standard.* (i) Except as provided in paragraph (c)(4) of this section, the total amount an APM Entity potentially owes CMS or foregoes under an APM must be at least equal to either:

(A) For QP Performance Periods beginning in 2017, through 2024, 8 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities; or

(B) 3 percent of the expected expenditures for which an APM Entity is responsible under the APM.

(ii) [Reserved]

(4) *Medical Home Model nominal amount standard.* (i) For a Medical Home Model to meet the Medical Home Model nominal amount standard, the total annual amount that an APM Entity potentially owes CMS or foregoes must be at least the following amounts:

(A) For QP Performance Period 2017, 2.5 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

(B) For QP Performance Period 2018, 2.5 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

(C) For QP Performance Period 2019, 3 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

(D) For QP Performance Period 2020, 4 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

(E) For QP Performance Periods 2021 and later, 5 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

(ii) [Reserved]

(5) *Expected expenditures.* For the purposes of this section, expected expenditures is defined as the beneficiary expenditures for which an APM Entity is responsible under an APM. For episode payment models, expected expenditures mean the episode target price.

(6) *Capitation.* A full capitation arrangement meets this Advanced APM criterion. For purposes of this part, a full capitation arrangement means a payment arrangement in which a per capita or otherwise predetermined payment is made under the APM for all items and services furnished to a population of beneficiaries during a fixed period of time, and no settlement is performed to reconcile or share losses incurred or savings earned by the APM Entity. Arrangements between CMS and Medicare Advantage Organizations under the Medicare Advantage program (42 U.S.C. 422) are not considered capitation arrangements for purposes of this paragraph (c)(6).

(7) *Medical Home Model 50 eligible clinician limit.* Notwithstanding paragraphs (c)(2) and (4) of this section, beginning in the 2018 QP Performance Period, if

an APM Entity participating in a Medical Home Model other than Round 1 of the Comprehensive Primary Care Plus (CPC+) Model is owned and operated by an organization with 50 or more eligible clinicians whose Medicare billing rights have been reassigned to the TIN(s) of the organization(s) or any of the organization's subsidiary entities, the requirements of paragraphs (c)(1) and (c)(3) of this section apply.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53960, Nov. 16, 2017; 83 FR 60090, Nov. 23, 2018]

EFFECTIVE DATE NOTES: 1. At 83 FR 60090, Nov. 23, 2018, section 414.1415 was amended by revising paragraphs (b)(2) and (3), effective Jan. 1, 2010. For the convenience of the user, the revised text is set forth as follows:

§ 414.1415 Advanced APM criteria.

* * * * *

(b) * * *

(2) At least one of the quality measures used in the payment arrangement as specified in paragraph (b)(1) of this section must:

(i) For QP Performance Periods before January 1, 2020, have an evidence-based focus, be reliable and valid, and meet at least one of the following criteria:

(A) Used in the MIPS quality performance category, as described in § 414.1330;

(B) Endorsed by a consensus-based entity;

(C) Developed under section 1848(s) of the Act;

(D) Submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act; or

(E) Any other quality measures that CMS determines to have an evidence-based focus and to be reliable and valid; and

(ii) For QP Performance Periods beginning on or after January1, 2020, be:

(A) Finalized on the MIPS final list of measures, as described in § 414.1330;

(B) Endorsed by a consensus-based entity; or

(C) Determined by CMS to be evidenced-based, reliable, and valid.

(3) In addition to the quality measure described under paragraph (b)(2) of this section, the quality measures upon which an Advanced APM bases the payment in paragraph (b)(1) of this section must include at least one additional measure that is an outcome measure unless CMS determines that there are no available or applicable outcome measures included in the MIPS final quality measures list for the Advanced APM's first QP Performance Period. Beginning January 1, 2020, the included outcome measure must satisfy the criteria in paragraph (b)(2) of this section.

* * * * *

2. At 84 FR 540, Jan. 31, 2019, in amendatory instruction 41 on page 60090, in the second column, in line 2, the parenthetical ''(effective January 1, 2010)'' denoting the effective date of the rule was corrected to read ''(effective January 1, 2020)''.

§ 414.1420 Other payer advanced APM criteria.

(a) *Other Payer Advanced APM criteria.* A payment arrangement with a payer other than Medicare is an Other Payer Advanced APM for a QP Performance Period if CMS determines that the arrangement meets the following criteria during the QP Performance Period:

(1) Use of CEHRT, as described in paragraph (b) of this section;

(2) Quality measures comparable to measures under the MIPS quality performance category apply, as described in paragraph (c) of this section; and

(3) Either:

(i) Requires APM Entities to bear more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures as described in paragraph (d) of this section; or

(ii) Is a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Act as described in paragraph (d) of this section.

(b) *Use of CEHRT.* To be an Other Payer Advanced APM, an other payer arrangement must require participants to use CEHRT as defined in § 414.1305. The other payer arrangement must require at least 50 percent of eligible clinicians in each participating APM Entity group, or each hospital if hospitals are the APM Entities, to use CEHRT to document and communicate clinical care.

(c) *Use of quality measures.* (1) To be an Other Payer Advanced APM, a payment arrangement must apply quality measures comparable to measures under the MIPS quality performance category, as described in paragraph (c)(2) of this section.

(2) At least one of the quality measures used in the payment arrangement

must have an evidence-based focus, be reliable and valid, and meet at least one of the following criteria:

(i) Used in the MIPS quality performance category, as described in §414.1330;

(ii) Endorsed by a consensus-based entity;

(iii) Developed under section 1848(s) of the Act;

(iv) Submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act; or

(v) Any other quality measures that CMS determines to have an evidence-based focus and to be reliable and valid.

(3) To meet the quality measure use criterion, a payment arrangement must use an outcome measure if there is an applicable outcome measure on the MIPS quality measure list.

(d) *Financial risk.* To be an Other Payer Advanced APM, except as described in paragraph (d)(7) of this section, a payment arrangement must meet either the financial risk standard under paragraph (d)(1) or (2) of this section and the nominal amount standard under paragraph (d)(3) or (4) of this section, or be a Medicaid Medical Home Model with criteria comparable to an expanded Medical Home Model under section 1115A(c) of the Act.

(1) *Generally applicable financial risk standard.* Except for APM Entities to which paragraph (d)(2) of this section applies, to be an Other Payer Advanced APM, an APM Entity must, based on whether an APM Entity's actual expenditures for which the APM Entity is responsible under the payment arrangement exceed expected expenditures during a specified period of performance do one or more of the following:

(i) Withhold payment for services to the APM Entity or the APM Entity's eligible clinicians;

(ii) Reduce payment rates to the APM Entity or the APM Entity's eligible clinicians; or

(iii) Require direct payment by the APM Entity to the payer.

(2) *Medicaid Medical Home Model financial risk standard.* The APM Entity participates in a Medicaid Medical Home Model that, based on the APM Entity's failure to meet or exceed one or more specified performance standards, does one or more of the following:

(i) Withhold payment for services to the APM Entity or the APM Entity's eligible clinicians;

(ii) Require direct payment by the APM Entity to the Medicaid program;

(iii) Reduce payment rates to the APM Entity or the APM Entity's eligible clinicians; or

(iv) Require the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.

(3) *Generally applicable nominal amount standard.* Except for payment arrangements described in paragraph (d)(2) of this section, the total amount an APM Entity potentially owes a payer or foregoes under a payment arrangement must be at least:

(i) For QP Performance Periods 2019 through 2024, 8 percent of the total combined revenues from the payer to providers and other entities under the payment arrangement if financial risk is expressly defined in terms of revenue; or, 3 percent of the expected expenditures for which an APM Entity is responsible under the payment arrangement.

(ii) Except for risk arrangements described under paragraph (d)(2) of this section, the risk arrangement must have:

(A) A marginal risk rate of at least 30 percent; and

(B) Total potential risk of at least 4 percent of expected expenditures.

(4) *Medicaid Medical Home Model nominal amount standard.* For a Medicaid Medical Home Model to meet the Medicaid Medical Home Model nominal amount standard, the total annual amount that an APM Entity potentially owes a payer or foregoes must be at least the following amounts:

(i) For QP Performance Period 2019, 3 percent of the average estimated total revenue of the participating providers or other entities under the payer.

(ii) For QP Performance Period 2020, 4 percent of the average estimated total revenue of the participating providers or other entities under the payer.

(iii) For QP Performance Periods 2021 and later, 5 percent of the average estimated total revenue of the participating providers or other entities under the payer.

(5) *Marginal risk rate.* For purposes of this section, the marginal risk rate is defined as the percentage of actual expenditures that exceed expected expenditures for which an APM Entity is responsible under an APM.

(i) In the event that the marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, the lowest marginal risk rate across all possible levels of actual expenditures would be used for comparison to the marginal risk rate specified in paragraph (d)(3)(ii)(A) of this section, with exceptions for large losses as described in paragraph (d)(5)(ii) of this section and small losses as described in paragraph (d)(5)(iii) of this section.

(ii) Allowance for large losses. The determination in paragraph (d)(3)(ii)(A) of this section may disregard the marginal risk rates that apply in cases when actual expenditures exceed expected expenditures by an amount sufficient to require the APM Entity to make financial risk payments under the Other Payer Advanced APM greater than or equal to the total risk requirement under paragraph (d)(3)(i) of this section.

(iii) Allowance for minimum loss rate. The determination in paragraph (d)(3)(ii)(A) of this section may disregard the marginal risk rates that apply in cases when actual expenditures exceed expected expenditures by less than 4 percent of expected expenditures.

(6) *Expected expenditures.* For the purposes of this section, expected expenditures is defined as the Other Payer Advanced APM benchmark, except for episode payment models, for which it is defined as the episode target price.

(7) *Capitation.* A full capitation arrangement meets this Other Payer Advanced APM criterion. For purposes of paragraph (d)(3) of this section, a full capitation arrangement means a payment arrangement in which a per capita or otherwise predetermined payment is made under the payment arrangement for all items and services furnished to a population of beneficiaries during a fixed period of time, and no settlement is performed for the purpose of reconciling or sharing losses incurred or savings earned by the participant. Arrangements made directly between CMS and Medicare Advantage Organizations under the Medicare Advantage program (42 U.S.C. 422) are not considered capitation arrangements for purposes of this paragraph (c)(7).

(8) *Medicaid Medical Home Model 50 eligible clinician limit.* Notwithstanding paragraphs (d)(2) and (4) of this section, beginning in the 2019 QP Performance Period, if an APM Entity participating in a Medicaid Medical Home Model is owned and operated by an organization with 50 or more eligible clinicians whose Medicare billing rights have been reassigned to the TIN(s) of the organization(s) or any of the organization's subsidiary entities, the requirements of paragraphs (d)(1) and (3) of this section apply.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53961, Nov. 16, 2017; 83 FR 23610, May 22, 2018; 83 FR 60090, Nov. 23, 2018]

EFFECTIVE DATE NOTE: At 83 FR 60090, Nov. 23, 2018, section 414.1420 was amended by revising paragraphs (b), (c)(2) and (3), effective Jan. 1, 2020. For the convenience of the user, the revised text is set forth as follows:

§ 414.1420 Other payer advanced APM criteria.

* * * * *

(b) *Use of CEHRT.* To be an Other Payer Advanced APM, CEHRT must be used by at least 50 percent, or for QP Performance Periods on or after January 1, 2020, 75 percent of participants in each participating APM Entity group, or each hospital if hospitals are the APM Entities, in the other payer arrangement to document and communicate clinical care.

(c) * * *

(2) At least one of the quality measures used in the payment arrangement as specified in paragraph (c)(1) of this section must:

(i) For QP Performance Period before January 1, 2020, have an evidence-based focus, be reliable and valid, and meet at least one of the following criteria:

(A) Used in the MIPS quality performance category, as described in § 414.1330;

(B) Endorsed by a consensus-based entity;

(C) Developed under section 1848(s) of the Act;

(D) Submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act; or

(E) Any other quality measures that CMS determines to have an evidence-based focus and to be reliable and valid; and

(ii) For QP Performance Periods beginning on or after January 1, 2020, be:

(A) Finalized on the MIPS final list of measures, as described in §414.1330;

(B) Endorsed by a consensus-based entity; or

(C) Determined by CMS to be evidenced-based, reliable, and valid.

(3) To meet the quality measure use criterion under paragraph (c)(1) of this section, a payment arrangement must:

(i) For QP Performance Periods before January 1, 2020, use an outcome measure if there is an applicable outcome measure on the MIPS quality measure list. This criterion also applies for payment arrangements determined to be Other Payer Advanced APMs on or before January 1, 2020, but only for the Other Payer Advanced APM determination made with respect to the arrangement for the CY 2020 QP Performance Period (regardless of whether that determination is a single- or multi-year determination).

(ii) For QP Performance Periods on or after January 1, 2020, in addition to the quality measure described under paragraph (c)(2) of this section, use at least one additional measure that is an outcome measure and meets the criteria in paragraph (c)(2)(ii) of this section if there is such an applicable outcome measure on the MIPS quality measure list.

* * * * *

§414.1425 Qualifying APM participant determination: In general.

(a) *List used for QP determination.* (1) For Advanced APMs in which all APM Entities may include eligible clinicians on a Participation List, the Participation List is used to identify the APM Entity group for purposes of QP determinations, regardless of whether the APM Entity may also include eligible clinicians on an Affiliated Practitioner List.

(2) For Advanced APMs in which APM Entities do not include eligible clinicians on a Participation List but do include eligible clinicians on an Affiliated Practitioner List, the Affiliated Practitioner List is used to identify the eligible clinicians for purposes of QP determinations.

(3) For Advanced APMs in which some APM Entities may include eligible clinicians on a Participation List and other APM Entities may only include eligible clinicians on an Affiliated Practitioner List depending on the type of APM Entity, paragraph (a)(1) of this section applies to APM Entities that may include eligible clinicians on a Participation List, and paragraph (a)(2) of this section applies to APM Entities that may only include eligible clinicians on an Affiliated Practitioner List.

(b) *Group or individual determination under the Medicare Option. (1) APM Entity group determination.* Except for paragraphs (b)(2) and (3) of this section and as set forth in §414.1440, for purposes of the QP determinations for a year, eligible clinicians are grouped and assessed through their collective participation in an APM Entity group that is in an Advanced APM. To be included in the APM Entity group for purposes of the QP determination, an eligible clinician's APM participant identifier must be present on a Participation List of an APM Entity group on one of the dates: March 31, June 30, or August 31 of the QP Performance Period. An eligible clinician included on a Participation List on any one of these dates is included in the APM Entity group even if that eligible clinician is not included on that Participation List at one of the prior or later listed dates. CMS performs QP determinations for the eligible clinicians in an APM entity group three times during the QP Performance Period using claims data for services furnished from January 1 through each of the respective QP determination dates: March 31, June 30, and August 31. An eligible clinician can only be determined to be a QP if the eligible clinician appears on the Participation List on a date (March 31, June 30, or August 31) CMS uses to determine the APM Entity group and to make QP determinations collectively for the APM Entity group based on participation in the Advanced APM.

(2) *Affiliated practitioner individual determination under the Medicare Option.* For Advanced APMs to which paragraph (a)(2) of this section applies, QP determinations are made individually for each eligible clinician. To be assessed as an Affiliated Practitioner, an eligible clinician must be identified on

an Affiliated Practitioner List on one of the dates: March 31, June 30, or August 31 of the QP Performance Period. An eligible clinician included on an Affiliated Practitioner List on any one of these dates is assessed as an Affiliated Practitioner even if that eligible clinician is not included on the Affiliated Practitioner List at one of the prior or later listed dates. For such eligible clinicians, CMS performs QP determinations during the QP Performance Period using claims data for services furnished from January 1 through each of the respective QP determination dates that the eligible clinician is on the Affiliated Practitioner List: March 31, June 30, and August 31.

(c) *QP determination.* (1) CMS makes QP determinations as set forth in §§ 414.1435 and 414.1440.

(2) An eligible clinician cannot be both a QP and a Partial QP for a year. A determination that an eligible clinician is a QP means that the eligible clinician is not a Partial QP.

(3) An eligible clinician is a QP for a year under the Medicare Option if the eligible clinician is in an APM Entity group that achieves a Threshold Score that meets or exceeds the corresponding QP payment amount threshold or QP patient count threshold for that QP Performance Period as described in § 414.1430(a)(1) and (3). An eligible clinician is a QP for the year under the All-Payer Combination Option if the eligible clinician individually, or as part of an APM Entity group, achieves a Threshold Score that meets or exceeds the corresponding QP payment amount threshold or QP patient count threshold for that QP Performance Period as described in § 414.1430(b)(1) and (3).

(4) Notwithstanding paragraph (c)(3) of this section, an eligible clinician is a QP for a year if:

(i) The eligible clinician is included in more than one APM Entity group and none of the APM Entity groups in which the eligible clinician is included meets the QP payment amount threshold or the QP patient count threshold, or the eligible clinician is an Affiliated Practitioner; and

(ii) CMS determines that the eligible clinician individually achieves a Threshold Score that meets or exceeds the QP payment amount threshold or the QP patient count threshold.

(5) Notwithstanding paragraph (c)(3) of this section, an eligible clinician is not a QP for a year if the APM Entity group voluntarily or involuntarily terminates from an Advanced APM before the end of the QP Performance Period.

(6) Notwithstanding paragraph (c)(4) of this section, an eligible clinician is not a QP for a year if one or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the QP Performance Period, and the eligible clinician does not individually achieve a Threshold Score that meets or exceeds the QP payment amount threshold or QP patient count threshold based on participation in the remaining non-terminating APM Entities.

(7) Advanced APMs that start or end during the QP Performance Period:

(i) Notwithstanding paragraph (a) of this section and §§ 414.1435 and 414.1440, CMS makes QP determinations and Partial QP determinations for the APM Entity group or individual eligible clinician under § 414.1425(b) for Advanced APMs that start or end during the QP Performance Period and that are actively tested for 60 or more continuous days during the QP Performance Period using claims data for services furnished during those dates on which the Advanced APM is actively tested. For Advanced APMs that start active testing during the QP Performance Period, CMS performs QP and Partial QP determinations during the QP Performance Period using claims data for services furnished from the start of active testing of the Advanced APM through each of the QP determination dates that occur on or after the Advanced APM has been actively tested for 60 or more continuous days: March 31, June 30, and August 31. For Advanced APMs that end active testing during the QP Performance Period, CMS performs QP and Partial QP determinations using claims data for services furnished from January 1 or the start of active testing, whichever occurs later, through the final day of active testing of the Advanced APM for each of the QP determination dates that occur on or after the Advanced APM has been actively

tested for 60 or more continuous days during that QP Performance Period: March 31, June 30, and August 31.

(ii) For QP determinations specified under paragraph (c)(4) of this section and Partial QP determinations under paragraph (d)(2) of this section, QP determinations are made using claims data for the full QP Performance Period even if the eligible clinician participates in one or more Advanced APMs that start or end during the QP Performance Period.

(d) *Partial QP determination.* (1) An eligible clinician is a Partial QP for a year under the Medicare Option if the eligible clinician is in an APM Entity group that achieves Threshold Score that meets or exceeds the corresponding Partial QP payment amount threshold or Partial QP patient count threshold for that QP Performance Period as described in §414.1430(a)(2) and (4). An eligible clinician is a Partial QP for the year under the All-Payer Combination Option if the eligible clinician achieves individually, or as part of an APM Entity group, a Threshold Score that meets or exceeds the corresponding Partial QP payment amount threshold or Partial QP patient count threshold for that QP Performance Period as described in §414.1430(b)(2) and (4).

(2) Notwithstanding paragraph (d)(1) of this section, an eligible clinician is a Partial QP for a year if:

(i) The eligible clinician is included in more than one APM Entity group and none of the APM Entity groups in which the eligible clinician is included meets the corresponding QP or Partial QP threshold, or the eligible clinician is an Affiliated Practitioner; and

(ii) CMS determines that the eligible clinician individually achieves a Threshold Score that meets or exceeds the corresponding Partial QP Threshold.

(3) Notwithstanding paragraph (d)(1) of this section, an eligible clinician is not a Partial QP for a year if the APM Entity group voluntarily or involuntarily terminates from an Advanced APM before the end of the QP Performance Period.

(4) Notwithstanding paragraph (d)(2) of this section, an eligible clinician is not a Partial QP for a year if one or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the QP Performance Period, and the eligible clinician does not individually achieve a Threshold Score that meets or exceeds the Partial QP payment amount threshold or Partial QP patient count threshold based on participation in the remaining non-terminating APM Entities.

(e) *Notification of QP determination.* CMS notifies eligible clinicians determined to be QPs or Partial QPs for a year as soon as practicable following each QP determination date in the QP Performance Period.

(f) *Order of threshold options.* (1) For payment years 2019 and 2020, CMS performs QP determinations for an eligible clinicians only under the Medicare Option described in §414.1435.

(2) For payment years 2021 and later, CMS performs QP determinations for eligible clinicians under the Medicare Option, as described in §414.1435 and, except as specified in paragraphs (d)(2)(i) and (ii) of this section, the All-Payer Combination Option, described in §414.1440.

(i) If CMS determines the eligible clinician to be a QP under the Medicare Option, then CMS does not calculate a Threshold Score for such eligible clinician under the All-Payer Combination Option.

(ii) If the Threshold Score for an eligible clinician under the Medicare Option is less than the amount specified in §414.1430(b)(2)(ii) and (b)(3)(iii), then CMS does not perform a QP determination for such eligible clinician(s) under the All-Payer Combination Option.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53961, Nov. 16, 2017]

§414.1430 Qualifying APM participant determination: QP and partial QP thresholds.

(a) *Medicare Option*—(1) *QP payment amount threshold.* The QP payment amount thresholds are the following values for the indicated payment years:

(i) 2019 and 2020: 25 percent.

(ii) 2021 and 2022: 50 percent.

(iii) 2023 and later: 75 percent.

(2) *Partial QP payment amount threshold.* The Partial QP payment amount

thresholds are the following values for the indicated payment years:

(i) 2019 and 2020: 20 percent.

(ii) 2021 and 2022: 40 percent.

(ii) 2023 and later: 50 percent.

(3) *QP patient count threshold.* The QP patient count thresholds are the following values for the indicated payment years:

(i) 2019 and 2020: 20 percent

(ii) 2021 and 2022: 35 percent

(ii) 2023 and later: 50 percent

(4) *Partial QP patient count threshold.* The Partial QP patient count thresholds are the following values for the indicated payment years:

(i) 2019 and 2020: 10 percent

(ii) 2021 and 2022: 25 percent

(iii) 2023 and later: 35 percent

(b) *All-Payer Combination Option*—(1) *QP payment amount threshold.*

(i) The QP payment amount thresholds are the following values for the indicated payment years:

(A) 2021 and 2022: 50 percent.

(B) 2023 and later: 75 percent.

(ii) To meet the QP payment amount threshold under this option, the eligible clinician must also meet a 25 percent QP payment amount threshold under the Medicare Option.

(2) *Partial QP payment amount threshold.* (i) The Partial QP payment amount thresholds are the following values for the indicated payment years:

(A) 2021 and 2022: 40 percent.

(B) 2023 and later: 50 percent.

(ii) To meet the QP payment amount threshold under this option, the eligible clinician must also meet a 20 percent Partial QP payment amount threshold under the Medicare Option.

(3) *QP patient count threshold.* (i) The QP patient count thresholds are the following values for the indicated payment years:

(A) 2021 and 2022: 35 percent.

(B) 2023 and later: 50 percent.

(ii) To meet the QP patient count threshold under this option, the eligible clinician must also meet a 20 percent QP patient count threshold under the Medicare Option.

(4) *Partial QP patient count threshold.* (i) The Partial QP patient count thresholds are the following values for the indicated payment years:

(A) 2021 and 2022: 25 percent.

(B) 2023 and later: 35 percent.

(ii) To meet the Partial QP patient count threshold under this option, the eligible clinician group or eligible clinician must also meet a 10 percent QP patient count threshold under the Medicare Option.

§ 414.1435 Qualifying APM participant determination: Medicare option.

(a) *Payment amount method.* The Threshold Score for an APM Entity or eligible clinician is calculated as a percent by dividing the value described under paragraph (a)(1) of this section by the value described under paragraph (a)(2) of this section.

(1) *Numerator.* The aggregate of payments for Medicare Part B covered professional services furnished by the APM Entity group to attributed beneficiaries during the QP Performance Period.

(2) *Denominator.* The aggregate of payments for Medicare Part B covered professional services furnished by the APM Entity group to all attribution-eligible beneficiaries during the QP Performance Period.

(3) *Claims and adjustments.* In the calculations under paragraphs (a)(1) and (2) of this section, CMS compiles claims and treats claims adjustments, supplemental service payments, and alternative payment methods in the same manner as described in § 414.1450.

(b) *Patient count method.* The Threshold Score for each eligible clinician in an APM Entity group is calculated as a percent under the patient count method by dividing the value described under paragraph (b)(1) of this section by the value described under paragraph (b)(2) of this section.

(1) *Numerator.* The number of attributed beneficiaries to whom the APM Entity group furnishes Medicare Part B covered professional services or services by a Rural Health Clinic (RHC) or Federally-Qualified Health Center (FQHC) during the QP Performance Period.

(2) *Denominator.* The number of attribution-eligible beneficiaries to whom the APM Entity group or eligible clinician furnish Medicare Part B covered professional services or services by a Rural Health Clinic (RHC) or Federally-Qualified Health Center (FQHC) during the QP Performance Period.

(3) *Unique beneficiaries.* For each APM Entity group, a unique Medicare beneficiary is counted no more than one time for the numerator and no more than one time for the denominator.

(4) *Beneficiaries count multiple times.* Based on attribution under the terms of an Advanced APM, a single Medicare beneficiary may be counted in the numerator or denominator for multiple different APM Entity groups.

(c) *Attribution.* (1) Attributed beneficiaries are determined from Advanced APM attributed beneficiary lists generated by each Advanced APM's specific attribution methodology.

(2) When operationally feasible, this attributed beneficiary list will be the final beneficiary list used for reconciliation purposes in the Advanced APM.

(3) When it is not operationally feasible to use the final attributed beneficiary list, the attributed beneficiary list will be taken from the Advanced APM's most recently available attributed beneficiary list at the end of the QP Performance Period.

(d) *Use of methods.* CMS calculates Threshold Scores for an APM Entity or eligible clinician as provided by §414.1425(b) under both the payment amount and patient count methods for each QP Performance Period. CMS then assigns to the eligible clinicians included in the APM Entity group or to the eligible clinician the score that results in the greater QP status. QP status is greater than Partial QP status, and Partial QP status is greater than no QP status.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53963, Nov. 16, 2017]

§414.1440 Qualifying APM participant determination: All-payer combination option.

(a) *Payments excluded from calculations.* (1) These calculations include a combination of both Medicare payments for Part B covered professional services and all other payments for all other payers, except for payments made by:

(i) The Secretary of Defense for the costs of Department of Defense health care programs;

(ii) The Secretary of Veterans Affairs for the cost of Department of Veterans Affairs health care programs; and

(iii) Under Title XIX in a State in which no Medicaid APM or Medicaid Medical Home Model that is an Other Payer Advanced APM is available.

(2) Payments and associated patient counts under paragraph (a)(1)(iii) of this section are included in the numerator and denominator as specified in paragraphs (b)(2) and (3) and paragraphs (c)(2) and (3) of this section for an eligible clinician if CMS determines that there is at least one Medicaid APM or Medicaid Medical Home Model that is an Other Payer Advanced APM available in the county where the eligible clinician sees the most patients during the QP Performance Period, and that the eligible clinician is not ineligible to participate in the Other Payer Advanced APM based on their specialty.

(b) *Payment amount method*—(1) *In general.* The Threshold Score for either an APM Entity group or eligible clinician will be calculated by dividing the value described under the numerator by the value described under the denominator as specified in paragraphs (b)(2) and (3) of this section.

(2) *Numerator.* The aggregate amount of all payments from all payers, except those excluded under paragraph (a) of this section, attributable to the eligible clinician or to the APM Entity group under the terms of all Advanced APMs and Other Payer Advanced APMs during the QP Performance Period.

(3) *Denominator.* The aggregate amount of all payments from all payers, except those excluded under paragraph (a) of this section, made to the eligible clinician or to the APM Entity group during the QP Performance Period.

(c) *Patient count method*—(1) *In general.* The Threshold Score for either an APM Entity group or eligible clinician is calculated by dividing the value described under the numerator by the value described under the denominator as specified in paragraphs (c)(2) and (3) of this section.

(2) *Numerator.* The number of unique patients to whom an APM Entity group or eligible clinician furnishes services that are included in the measures of aggregate expenditures used under the terms of all Advanced APMs and Other

Payer Advanced APMs during the QP Performance Period.

(3) *Denominator*. The number of unique patients to whom the APM Entity group or eligible clinician furnishes services under all non-excluded payers during the QP Performance Period.

(4) *Unique patients*. CMS may count a single patient in the numerator and/or denominator for multiple different payers.

(d) *QP Determinations under the All-Payer Combination Option*. (1) CMS performs QP determinations following the QP Performance Period using payment amount and/or patient count information submitted from January 1 through each of the respective QP determination dates: March 31, June 30, and August 31. CMS will use data for the same time periods for the Medicare and other payer portions of Threshold Score calculations under the All-Payer Combination Option. CMS will use the payment amount or patient count method, applying the more advantageous of the two for both the Medicare and other payer portions of the Threshold score calculation, regardless of the method used for the Medicare Threshold Score calculation.

(2) An APM Entity may request that CMS make QP determinations at the APM Entity level, an eligible clinician may request that CMS make QP determinations at the eligible clinician level, and an eligible clinician or an APM Entity may request that CMS makes QP determinations at the TIN-level in instances where all clinicians who reassigned billing rights to the TIN are participating in a single APM Entity. CMS makes QP determinations at either the APM Entity, eligible clinician, or TIN level. Eligible clinicians assessed at the eligible clinician level under the Medicare Option at § 414.1425(b)(2) will be assessed at the eligible clinician level only under the All-Payer Combination Option. Eligible Clinicians may meet the Medicare and the All-Payer Combination Option thresholds using the payment amount method for both thresholds, the patient account method for both thresholds, or the payment amount method for one threshold and the patient account method for the other threshold.

(3) CMS uses data at the same level for the Medicare and other payer portions of Threshold Score calculations under the All-Payer Combination Option. When QP determinations are made at the eligible clinician or, at the TIN level when all clinicians who have reassigned billing rights to the TIN are included in a single APM Entity; and if the Medicare Threshold score for the APM Entity group is higher than when calculated for the eligible clinician or TIN, CMS makes QP determinations using a weighted Medicare Threshold Score that is factored into an All-Payer Combination Option Threshold Score.

(e) *Information used to calculate Threshold Scores under the All-Payer Combination Option*. (1) An APM Entity or eligible clinician may request as set forth in § 414.1445(b)(2) that CMS determine whether a payment arrangement in which they participate meets the Other Payer Advanced APM criteria and may demonstrate participation in an Other Payer Advanced APM determined as a result of a request made in § 414.1445(a)(1) or (b)(1) in a form and manner specified by CMS.

(2) To request a QP determination under the All-Payer Combination Option, for each payment arrangement submitted as set forth in paragraph (e)(1) of this section, the APM Entity or eligible clinician must include the amount of revenue for services furnished through the payment arrangement, the total revenue received from all payers except those excluded as provided in paragraph (a)(2) of this section, the number of patients furnished any service through the arrangement, and the total number of patients furnished any services, except those excluded as provided in paragraph (a)(2) of this section.

(3) An APM Entity or eligible clinician must submit the information specified in paragraph (e)(2) of this section in a form and manner specified by CMS. An APM Entity or eligible clinician may submit the information specified in paragraph (e)(2) of this section for the following periods of time in the relevant QP Performance Period: January 1 through March 31, January 1 through June 30, and January 1 through August 31.

(4) To request a QP determination under the All-Payer Combination Option, an APM Entity or eligible clinician must submit this information to CMS no later than the QP Determination Submission Deadline, which is December 1 of the calendar year that is 2 years prior to the payment year.

(f) *Requirement to submit sufficient information*—(1) *Sufficient Information*. CMS makes a QP determination with respect to the eligible clinician under the All-Payer Combination Option only if the APM Entity or eligible clinician submits the information required under paragraph (e) of this section sufficient for CMS to assess the eligible clinician under either the payment amount or patient count as described in paragraphs (b) and (c) of this section.

(2) *Certification*. The APM Entity or eligible clinician who submits information to request a QP determination under the All-Payer Combination Option must certify that the information submitted to CMS is true, accurate, and complete. Such certification must accompany the submission and be made at the time of submission. In the case of information submitted by an APM Entity, the certification must be made by an individual with the authority to bind the APM Entity.

(g) *Notification of QP determination*. CMS notifies eligible clinicians determined to be QPs or Partial QPs for a year as soon as practicable after QP calculations are conducted.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53963, Nov. 16, 2017; 83 FR 60091, Nov. 23, 2018]

§414.1445 Determination of other payer advanced APMs.

(a) *Determination of Medicaid APMs*. Beginning in 2018, and each year thereafter, at a time determined by CMS, a state, APM Entity, or eligible clinician may request, in a form and manner specified by CMS, that CMS determine whether a payment arrangement authorized under Title XIX is either a Medicaid APM or a Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria as set forth in §414.1420. A state must submit its request by April 1 of the year prior to the relevant QP Performance Period, and an APM Entity or eligible clinician must submit its request by November 1 of the year prior to the relevant QP Performance Period. CMS will not determine that a payment arrangement is a Medicaid APM or Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria as set forth in §414.1420 for a year after the relevant QP Performance Period.

(b) *Determination of Other Payer Advanced APMs*—(1) *Payer initiated Other Payer Advanced APM determination process*. Beginning in 2018, and each year thereafter, at a time determined by CMS a payer with a Medicare Health Plan payment arrangement may request, in a form and manner specified by CMS, that CMS determine whether a Medicare Health Plan payment arrangement meets the Other Payer Advanced APM criteria set forth in §414.1420. A payer with a Medicare Health Plan payment arrangement must submit its requests by the annual Medicare Advantage bid deadline of the year prior to the relevant QP Performance Period. A Medicare Health Plan is a Medicare Advantage plan, a section 1876 cost plan, a PACE organization operated under section 1894, and any similar plan which provides Medicare benefits under demonstration or waiver authority (other than an APM as defined in section 1833(z)(3)(C) of the Act).

(2) *Eligible clinician initiated Other Payer Advanced APM determination process*. Except as provided by paragraph (a) of this section, at a time specified by CMS, an APM Entity or eligible clinician may request that CMS determine whether a payment arrangement meets the Other Payer Advanced APM criteria as set forth in §414.1420 in a form and manner specified by CMS. An APM Entity or eligible clinician must submit requests by December 1 of the calendar year of the relevant QP Performance Period.

(c) *Information required for Other Payer Advanced APM determinations*. (1) In order to make an Other Payer Advanced APM determination as set forth in paragraphs (a) and (b) of this section, a payer, APM Entity, or eligible clinician must submit the information specified by CMS in a form and manner

specified by CMS. If a payer, APM Entity, or eligible clinician fails to submit the information required, CMS will not make a determination as to whether a payment arrangement meets the Other Payer Advanced APM criteria as set forth in § 414.1420.

(2) If an eligible clinician submits information showing that a payment arrangement requires that the eligible clinician must use CEHRT as defined in § 414.1305 to document and communicate clinical care, CMS will presume that the CEHRT criterion in § 414.1420(b) is satisfied for that payment arrangement.

(i) Based on the submission by an eligible clinician or payer of evidence that CMS determines sufficiently demonstrates that CEHRT is used as specified in § 414.1420(b) by participants in the payment arrangement, CMS will consider the CEHRT criterion in § 414.1420(b) is satisfied for that payment arrangement.

(ii) [Reserved]

(3) If a payment arrangement has no outcome measure, the payer, APM Entity, or eligible clinician requesting a determination of whether a payment arrangement meets the Other Payer Advanced APM criteria must certify that there is no available or applicable outcome measure on the MIPS measure list.

(d) *Certification.* A payer, APM Entity, or eligible clinician that submits information pursuant to paragraph (c) of this section must certify that the information it submitted to CMS is true, accurate, and complete. Such certification must accompany the submission and be made at the time of submission. In the case of information submitted by a payer or an APM Entity, the certification must be made by an individual with the authority to bind the payer or the APM Entity.

(e) *Timing of Other Payer Advanced APM determinations.* CMS makes Other Payer Advanced APM determinations prior to making QP determinations under § 414.1440.

(f) *Notification of Other Payer Advanced APM determinations.* CMS makes Other Payer Advanced APM determinations and notifies the requesting payer, APM Entity, or eligible clinician of such determinations as soon as practicable following the relevant submission deadline.

[82 FR 53964, Nov. 16, 2017, as amended at 83 FR 60091, Nov. 23, 2018]

§ 414.1450 APM incentive payment.

(a) *In general.* (1) CMS makes a lump sum payment to QPs in the amount described in paragraph (b) of this section in the manner described in paragraphs (d) and (e) of this section.

(2) CMS provides notice of the amount of the APM Incentive Payment to QPs as soon as practicable following the calculation and validation of the APM Incentive Payment amount, but in any event no later than 1 year after the incentive payment base period.

(b) *APM Incentive Payment amount.* (1) The amount of the APM Incentive Payment is equal to 5 percent of the estimated aggregate payments for covered professional services as defined in section 1848(k)(3)(A) of the Act furnished during the calendar year immediately preceding the payment year.

(2) The estimated aggregate payment amount for covered professional services includes all such payments to any and all of the TIN/NPI combinations associated with the NPI of the QP.

(3) In calculating the estimated aggregate payment amount for a QP, CMS uses claims submitted with dates of service from January 1 through December 31 of the incentive payment base period, and processing dates of January 1 of the base period through March 31 of the subsequent payment year.

(4) The payment adjustment amounts, negative or positive, as described in sections 1848(m), (o), (p), and (q) of the Act are not included in calculating the APM Incentive Payment amount.

(5) Incentive payments made to eligible clinicians under sections 1833(m), (x), and (y) of the Act are not included in calculating the APM Incentive Payment amount.

(6) Financial risk payments such as shared savings payments or net reconciliation payments are excluded from the amount of covered professional services in calculating the APM Incentive Payment amount.

(7) Supplemental service payments in the amount of covered professional

services are included in calculating the APM Incentive Payment amount according to this paragraph (b). Supplemental service payments are included in the amount of covered professional services when calculating the APM Incentive Payment amount when the supplemental service payment meets the following four criteria:

(i) Is payment for services that constitute physicians services authorized under section 1832(a) and defined under section 1861(s) of the Act.

(ii) Is made for only Part B services under the criterion in paragraph (b)(9)(i) of this section.

(iii) Is directly attributable to services furnished to an individual beneficiary.

(iv) Is directly attributable to an eligible clinician, including an eligible clinician that is a group of individual eligible clinicians.

(8) For payment amounts that are affected by a cash flow mechanism, the payment amounts that would have occurred if the cash flow mechanism were not in place are used in calculating the APM Incentive Payment amount.

(c) *APM Incentive Payment recipient.* (1) CMS pays the entire APM Incentive Payment amount to the TIN associated with the QP's participation in the Advanced APM entity that met the applicable QP threshold during the QP Performance Period.

(2) In the event that an eligible clinician is no longer affiliated with the TIN associated with the QP's participation in the Advanced APM Entity that met the applicable QP threshold during the QP Performance Period at the time of the APM Incentive Payment distribution, CMS makes the APM Incentive Payment to the TIN listed on the eligible clinician's CMS–588 EFT Application form on the date that the APM Incentive Payment is distributed.

(3) In the event that an eligible clinician becomes a QP through participation in multiple Advanced APMs, CMS divides the APM Incentive Payment amount between the TINs associated with the QP's participation in each Advanced APM during the QP Performance Period. Such payments will be divided in proportion to the amount of payments associated with each TIN that the eligible clinician received for covered professional services during the QP Performance Period.

(d) *Timing of the APM Incentive Payment.* APM Incentive Payments made under this section are made as soon as practicable following the calculation and validation of the APM Incentive Payment amount, but in any event no later than 1 year after the incentive payment base period.

(e) *Treatment of APM Incentive Payment amount in APMs.* (1) APM Incentive Payments made under this section are not included in determining actual expenditures under an APM.

(2) APM Incentive Payments made under this section are not included in calculations for the purposes of rebasing benchmarks in an APM.

(f) *Treatment of APM Incentive Payment for other Medicare incentive payments and payment adjustments.* APM Incentive Payments made under this section will not be included in determining the amount of incentive payment made to eligible clinicians under section 1833(m), (x), and (y) of the Act.

§ 414.1455 Limitation on review.

There is no administrative or judicial review under sections 1869, 1878, or otherwise, of the Act of the following:

(a) The determination that an eligible clinician is a QP or Partial QP under § 414.1425 and the determination that an APM Entity is an Advanced APM Entity under § 414.1410.

(b) The determination of the amount of the APM Incentive Payment under § 414.1450, including any estimation as part of such determination.

§ 414.1460 Monitoring and program integrity.

(a) *Vetting eligible clinicians.* Prior to payment of the APM Incentive Payment, CMS determines if eligible clinicians were in compliance with all Medicare conditions of participation and the terms of the relevant Advanced APMs in which they participated during the QP Performance Period. A determination under this provision is not binding for other purposes.

(b) *Rescinding QP Determinations.* CMS may rescind a QP determination if:

(1) Any of the information CMS relied on in making the QP determination was inaccurate or misleading.

(2) The QP is terminated from an Advanced APM or Other Payer Advanced APM during the QP Performance Period or Incentive Payment Base Period; or

(3) The QP is found to be in violation of the terms of the relevant Advanced APM or any relevant Federal, State, or tribal statute or regulation during the QP Performance Period or Incentive Payment Base Period.

(c) *Information submitted for All-Payer Combination Option.* Information submitted by payers, APM Entities, or eligible clinicians for purposes of the All-Payer Combination Option may be subject to audit by CMS.

(d) *Reducing, denying, and recouping of APM Incentive Payments.* (1) CMS may reduce or deny an APM Incentive Payment to an eligible clinician.

(i) Who CMS determines is not in compliance with all Medicare conditions of participation and the terms of the relevant Advanced APM in which they participate during the QP Performance Period or Incentive Payment Base Period;

(ii) Who is terminated by an APM or Advanced APM during the QP Performance Period or Incentive Payment Base Period; or

(iii) Whose APM Entity is terminated by an APM or Advanced APM for noncompliance with any Medicare condition of participation or the terms of the relevant Advanced APM in which they participate during the QP Performance Period or Incentive Payment Base Period.

(2) CMS may reopen, revise, and recoup an APM Incentive Payment that was made in error in accordance with procedures similar to those set forth at §§ 405.980 through § 405.986 and §§ 405.370 through 405.379 of this chapter or as established under the relevant APM.

(e) *Maintenance of records.* (1) A payer that submits information to CMS under § 414.1445 for assessment under the All-Payer Combination Option must maintain such books, contracts, records, documents, and other evidence as necessary to enable the audit of an Other Payer Advanced APM determination. Such information and supporting documentation must be maintained for a period of 6 years after submission.

(2) An APM Entity or eligible clinician that submits information to CMS under § 414.1445 for assessment under the All-Payer Combination Option or § 414.1440 for QP determinations must maintain such books, contracts, records, documents, and other evidence as necessary to enable the audit of an Other Payer Advanced APM determination, QP determinations, and the accuracy of APM Incentive Payments for a period of 6 years from the end of the QP Performance Period or from the date of completion of any audit, evaluation, or inspection, whichever is later.

(3) A payer, APM Entity or eligible clinician that submits information to CMS under §§ 414.1440 or 414.1445 must provide such information and supporting documentation to CMS upon request.

(f) *OIG authority.* None of the provisions of this part limit or restrict OIG's authority to audit, evaluate, investigate, or inspect the Advanced APM Entity, its eligible clinicians, and other individuals or entities performing functions or services related to its APM activities.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53965, Nov. 16, 2017]

§ 414.1465 Physician-focused payment models.

(a) *Definition.* A physician-focused payment model (PFPM) is an Alternative Payment Model:

(1) In which Medicare is a payer;

(2) In which eligible clinicians that are eligible professionals as defined in section 1848(k)(3)(B) of the Act are participants and play a core role in implementing the APM's payment methodology; and

(3) Which targets the quality and costs of services that eligible professionals participating in the Alternative Payment Model provide, order, or can significantly influence.

(b) *Criteria.* In carrying out its review of physician-focused payment model proposals, the PTAC must assess

whether the physician-focused payment model meets the following criteria for PFPMs sought by the Secretary. The Secretary seeks PFPMs that:

(1) *Incentives: Pay for higher-value care.* (i) Value over volume: provide incentives to practitioners to deliver high-quality health care.

(ii) Flexibility: provide the flexibility needed for practitioners to deliver high-quality health care.

(iii) Quality and Cost: are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

(iv) Payment methodology: pay APM Entities with a payment methodology designed to achieve the goals of the PFPM Criteria. Addresses in detail through this methodology how Medicare, and other payers if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.

(v) Scope: aim to broaden or expand the CMS APM portfolio by addressing an issue in payment policy in a new way or including APM Entities whose opportunities to participate in APMs have been limited.

(vi) Ability to be evaluated: have evaluable goals for quality of care, cost, and any other goals of the PFPM.

(2) *Care delivery improvements: Promote better care coordination, protect patient safety, and encourage patient engagement.* (i) Integration and Care Coordination: encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

(ii) Patient Choice: encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

(iii) Patient Safety: aim to maintain or improve standards of patient safety.

(3) *Information Enhancements: Improving the availability of information to guide decision-making.* (i) Health Information Technology: encourage use of health information technology to inform care.

(ii) [Reserved]

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

Subpart A—General Provisions

Sec.

Subpart B—Fiscal Intermediary Payments to Providers for Physician Services

Subpart C—Part B Carrier Payments for Physician Services to Beneficiaries in Providers

Subpart D—Physician Services in Teaching Settings