

(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) *General.* (1) CMS posts on Physician Compare, in an easily understandable format, the following:

(i) Information regarding the performance of MIPS eligible clinicians, including, but not limited to, final scores and performance category scores for each MIPS eligible clinician; and

(ii) The names of eligible clinicians in Advanced APMs and, to the extent feasible, the names and performance of such Advanced APMs.

(2) CMS periodically posts on Physician Compare aggregate information on the MIPS, including the range of final scores for all MIPS eligible clinicians and the range of the performance of all MIPS eligible clinicians with respect to each performance category.

(3) The information made available under this section will indicate, where appropriate, that publicized information may not be representative of an eligible clinician's entire patient population, the variety of services furnished by the eligible clinician, or the health conditions of individuals treated.

(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) *New measures and activities.* (1) CMS does not publicly report any data on new quality or cost measure for the first 2 years in which it is in the program, after which CMS evaluates the measure to determine whether it is suitable for public reporting under paragraph (b) of this section.

(2) CMS does not publicly report any MVP data on new improvement activity or Promoting Interoperability measure, objective, or activity included in an MVP for the first year in which it is included in the MVP.

(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; 84 FR 63198, Nov. 15, 2019; 86 FR 65677, Nov. 19, 2021]

§414.1400 Third party intermediaries.

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

- (i) QCDR;
- (ii) Qualified registry;
- (iii) Health IT vendor; or
- (iv) CMS-approved survey vendor.

(2) Third party intermediary approval criteria—

(i) 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:

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

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

§ 414.1400

42 CFR Ch. IV (10–1–23 Edition)

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

(D) 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.

(E) The third party intermediary must provide services throughout the entire performance period and applicable data submission period.

(F) Prior to discontinuing services to any MIPS eligible clinician, group, virtual group, subgroup, or APM Entity during a performance period, the third party intermediary must support the transition of such MIPS eligible clinician, group, virtual group, subgroup, or APM Entity to an alternate third party intermediary, submitter type, or, for any measure on which data has been collected, collection type according to a CMS approved a transition plan.

(ii) The determination of whether to approve an entity as a third party intermediary for a MIPS payment year may take into account:

(A) Whether the entity failed to comply with the requirements of this section for any prior MIPS payment year for which it was approved as third party intermediary; and

(B) Whether the entity provided inaccurate information regarding the requirements of this subpart to any eligible clinician.

(iii) Beginning with the 2023 MIPS payment year, third party intermediaries must attend and complete training and support sessions in the form and manner, and at the times, specified by CMS.

(3) All data submitted to CMS by a third party intermediary on behalf of a MIPS eligible clinician, group, virtual group, subgroup, or APM Entity 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) *Additional requirements for QCDRs and qualified registries*—(1) *General*. (i) Beginning with the CY 2021 performance period/2023 MIPS payment year, QCDRs and qualified registries must be able to submit data for all of the following MIPS performance categories:

(A) Quality, except:

(1) The CAHPS for MIPS survey; and

(2) For qualified registries, QCDR measures;

(B) Improvement activities; and

(C) Promoting Interoperability, if the eligible clinician, group, virtual group, or subgroup is using CEHRT, unless the third party intermediary's MIPS eligible clinicians, groups, virtual groups, or subgroups fall under the reweighting policies at § 414.1380(c)(2)(i)(A)(4)(i) through (iii) or (c)(2)(i)(C)(1) through (7) or (c)(2)(i)(C)(9).

(ii) Beginning with the CY 2023 performance period/2025 MIPS payment year, QCDRs and qualified registries must support MVPs that are applicable to the MVP participant on whose behalf they submit MIPS data. QCDRs and qualified registries may also support the APP.

(2) *Self-nomination*. For the CY 2018 and 2019 performance periods/2020 and 2021 MIPS payment years, entities seeking to qualify as a QCDR or qualified registry must self-nominate September 1 until November 1 of the CY preceding the applicable performance period. For the CY 2020 performance period/2022 MIPS payment year and future years, entities seeking to qualify as a QCDR or 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 QCDR or 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 CY 2019 performance period/2021 MIPS payment year and future years, existing QCDRs and 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.

(3) *Conditions for approval*. (i) Beginning with the CY 2020 performance period/2022 MIPS payment year, the QCDR or qualified registry must have at least 25 participants by January 1 of the year prior to the applicable performance period.

(ii) If an entity seeking to qualify as a QCDR or qualified registry 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.

(iii) Beginning with the CY 2021 performance period/2023 MIPS payment year, the QCDR or qualified registry must provide performance feedback to their clinicians and groups at least 4 times a year, and provide specific feedback to their clinicians and groups on how they compare to other clinicians who have submitted data on a given measure within the QCDR or qualified registry. Exceptions to this requirement may occur if the QCDR or qualified registry submits notification to CMS within the performance period promptly within the month of realization of the impending deficiency and provides sufficient rationale as to why they do not believe they would be able to meet this requirement (for example, if the QCDR does not receive the data from their clinician until the end of the performance period).

(iv) Beginning with the CY 2023 performance period/2025 MIPS payment year, the QCDR or qualified registry must submit a data validation plan annually, at the time of self-nomination for CMS' approval and may not change the plan once approved without the prior approval of the agency.

(v) Beginning with the CY 2021 performance period/2023 MIPS payment year, the QCDR or qualified registry must conduct annual data validation audits in accordance with this paragraph (b)(3)(v).

(A) The QCDR or qualified registry must conduct data validation for the payment year prior to submitting any data for that payment year to CMS for purposes of the MIPS program.

(B) The QCDR or qualified registry must conduct data validation on data for each performance category for which it will submit data, including if applicable the Quality, Improvement

Activities, and Promoting Interoperability performance categories.

(C) The QCDR or qualified registry must conduct data validation on data for each submitter type for which it will submit data, including MIPS eligible clinicians, groups, virtual groups, subgroups, APM entities, voluntary participants, and opt-in participants, if applicable.

(D) The QCDR or qualified registry must use clinical documentation (provided by the clinicians they are submitting data for) to validate that the action or outcome measured actually occurred or was performed.

(E) The QCDR or qualified registry must conduct each data validation audit using a sampling methodology that meets the following requirements:

(1) Uses a sample size of at least 3 percent of the TIN/NPIs for which the QCDR or qualified registry will submit data to CMS, except that if a 3 percent sample size would result in fewer than 10 TIN/NPIs, the QCDR or qualified registry must use a sample size of at least 10 TIN/NPIs, and if a 3 percent sample size would result in more than 50 TIN/NPIs, the QCDR or qualified registry may use a sample size of 50 TIN/NPIs.

(2) Uses a sample that includes at least 25 percent of the patients of each TIN/NPI in the sample, except that the sample for each TIN/NPI must include a minimum of 5 patients and does not need to include more than 50 patients.

(F) Each QCDR or qualified registry data validation audit must include the following:

(1) Verification of the eligibility status of each eligible clinician, group, virtual group, subgroup, opt-in participant, and voluntary participant.

(2) Verification of the accuracy of TINs and NPIs.

(3) Calculation of reporting and performance rates.

(4) Verification that only the MIPS quality measures and QCDR measures, as applicable, that are relevant to the performance period will be used for MIPS submission.

(G) In a form and manner and by a deadline specified by CMS, the QCDR or qualified registry must report the results of each data validation audit, including the overall data deficiencies

or data error rate, the types of deficiencies or data errors discovered, the percentage of clinicians impacted by any deficiency or error, and, how and when each deficiency or data error type was corrected.

(1) QCDRs and qualified registries must conduct validation on the data they intend to submit for the MIPS performance period and provide the results of the executed data validation plan by May 31st of the year following the performance period.

(2) [Reserved]

(vi) Beginning with the CY 2021 performance period/2023 MIPS payment year, the QCDR or qualified registry must conduct targeted audits in accordance with this paragraph (b)(3)(vi).

(A) If a data validation audit under paragraph (b)(3)(v) of this section identifies one or more deficiency or data error, the QCDR or qualified registry must conduct a targeted audit into the impact and root cause of each such deficiency or data error for that MIPS payment year.

(B) The QCDR or qualified registry must conduct any required targeted audits for the MIPS payment year and correct any deficiencies or data errors identified through such audit prior to the submission of data for that MIPS payment year.

(C) The QCDR or qualified registry must conduct the targeted audit using the sampling methodology that meets the requirements described in paragraph (b)(3)(iv)(E) of this section. The sample for the targeted audit must not include data from the sample used for the data validation audit in which the deficiency or data error was identified.

(D) In a form and manner and by a deadline specified by CMS, the QCDR or qualified registry must report the results of each targeted audit, including the overall deficiency or data error rate, the types of deficiencies or data errors discovered, the percentage of clinicians impacted by each deficiency or data error, and how and when each deficiency or data error type was corrected.

(vii) For the CY 2023 performance period/2025 MIPS payment year, a QCDR or qualified registry that was approved but did not submit any MIPS data for any of the 2019 through 2023 MIPS pay-

ment years must submit a participation plan for CMS' approval. The participation plan must include the QCDR and/or qualified registry's detailed plans about how the QCDR or qualified registry intends to encourage clinicians to submit MIPS data to CMS through the QCDR or qualified registry.

(viii) Beginning with the CY 2024 performance period/2026 MIPS payment year, a QCDR or qualified registry that was approved but did not submit any MIPS data for either of the 2 years preceding the applicable self-nomination period must submit a participation plan for CMS' approval. This participation plan must include the QCDR's and/or qualified registry's detailed plans about how the QCDR or qualified registry intends to encourage clinicians to submit MIPS data to CMS through the QCDR or qualified registry.

(4) *QCDR measures for the quality performance category*—(i) *QCDR measure self-nomination requirements*. For the CY 2018 performance period/2020 MIPS payment year and future years, at the time of self-nomination an entity seeking to become a QCDR must submit the following information for any measure it intends to submit for the payment year.

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

(B) For a QCDR measure, the entity must submit for CMS approval measure specifications including: Name/title of measure, NQF number (if NQF-endorsed), descriptions of the denominator, numerator, and when applicable, denominator exceptions, denominator exclusions, risk adjustment variables, and risk adjustment algorithms. In addition, no later than 15 calendar days following CMS posting of all approved specifications for a QCDR measure, the entity must publicly post the CMS-approved measure specifications for the QCDR measure (including the CMS-assigned QCDR measure ID) and provide CMS with a link to where this information is posted.

(ii) *QCDR measure submission requirements*. A QCDR must include the CMS-

assigned QCDR measure ID when submitting data on any QCDR measure to CMS.

(iii) *QCDR measure approval criteria.* (A) QCDR measure requirements for approval are:

(1) QCDR measures that are beyond the measure concept phase of development.

(2) QCDR measures that address significant variation in performance.

(3) Beginning with the CY 2022 performance period/2024 MIPS payment year, CMS may approve a QCDR measure only if the QCDR measure meets face validity. Beginning with the CY 2024 performance period/2026 MIPS payment year, a QCDR measure approved for a previous performance year must be fully developed and tested, with complete testing results at the clinician level, prior to self-nomination.

(4) Beginning with the CY 2022 performance period/2023 MIPS payment year, QCDRs are required to collect data on a QCDR measure, appropriate to the measure type, prior to submitting the QCDR measure for CMS consideration during the self-nomination period.

(5) Beginning with the CY 2020 performance period/2022 MIPS payment year, CMS may provisionally approve the individual QCDR measures for 1 year with the condition that QCDRs address certain areas of duplication with other approved QCDR measures or MIPS quality measures in order to be considered for the program in subsequent years. If such areas of duplication are not addressed, CMS may reject the duplicative QCDR measure.

(B) QCDR measure considerations for approval include, but are not limited to:

(1) Measures that are outcome-based rather than clinical process measures.

(2) Measures that address patient safety and adverse events.

(3) Measures that identify appropriate use of diagnosis and therapeutics.

(4) Measures that address the domain of care coordination.

(5) Measures that address the domain for patient and caregiver experience.

(6) Measures that address efficiency, cost, and resource use.

(7) Beginning with the CY 2021 performance period/2023 MIPS payment year -

(i) That QCDRs link their QCDR measures as feasible to at least one cost measure, improvement activity, or an MVP at the time of self-nomination.

(ii) In cases where a QCDR measure does not have a clear link to a cost measure, improvement activity, or an MVP, CMS would consider exceptions if the potential QCDR measure otherwise meets the QCDR measure requirements and considerations.

(8) Beginning with the CY 2020 performance period/2022 MIPS payment year CMS may consider the extent to which a QCDR measure is available to MIPS eligible clinicians reporting through QCDRs other than the QCDR measure owner for purposes of MIPS. If CMS determines that a QCDR measure is not available to MIPS eligible clinicians, groups, and virtual groups reporting through other QCDRs, CMS may not approve the measure.

(9) Greater consideration is given to measures for which QCDRs:

(i) Conducted an environmental scan of existing QCDR measures; MIPS quality measures; quality measures retired from the legacy Physician Quality Reporting System (PQRS) program; and

(ii) Utilized the CMS Quality Measure Development Plan Annual Report and the Blueprint in the CMS Measures Management System to identify measurement gaps prior to measure development.

(10) Beginning with the CY 2020 performance period/2022 MIPS payment year, CMS places greater preference on QCDR measures that meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive CY performance periods. Those that do not, may not continue to be approved.

(i) Beginning with the CY 2020 performance period/2022 MIPS payment year, in instances where a QCDR believes the low-reported QCDR measure that did not meet benchmarking thresholds is still important and relevant to a specialist's practice, that the QCDR may develop and submit a QCDR measure participation plan for our consideration. This QCDR measure participation plan must include the

QCDR's detailed plans and changes to encourage eligible clinicians and groups to submit data on the low-reported QCDR measure for purposes of the MIPS program.

(ii) [Reserved]

(C) Beginning with the CY 2021 performance period/2023 MIPS payment year, QCDR measures may be approved for 2 years, at CMS discretion by attaining approval status by meeting QCDR measure considerations and requirements. Upon annual review, CMS may revoke a QCDR measure's second year approval, if the QCDR measure is found to be: Topped out; duplicative of a more robust measure; reflects an outdated clinical guideline; or if the QCDR self-nominating the QCDR measure is no longer in good standing.

(iv) *QCDR measure rejection criteria.* Beginning with the CY 2020 performance period/2022 MIPS payment year, QCDR measure rejection considerations include, but are not limited to:

(A) QCDR measures that are duplicative or identical to other QCDR measures or MIPS quality measures that are currently in the program.

(B) QCDR measures that are duplicative or identical to MIPS quality measures that have been removed from MIPS through rulemaking.

(C) QCDR measures that are duplicative or identical to quality measures used under the legacy Physician Quality Reporting System (PQRS) program, which have been retired.

(D) QCDR measures that meet the topped out definition as described at § 414.1305.

(E) QCDR measures that are process-based, with consideration to whether the removal of the process measure impacts the number of measures available for a specific specialty.

(F) Whether the QCDR measure has potential unintended consequences to a patient's care.

(G) Considerations and evaluation of the measure's performance data, to determine whether performance variance exists.

(H) QCDR measures that split a single clinical practice or action into several QCDR measures.

(I) QCDR measures that are "checkbox" with no actionable quality action.

(J) QCDR measures that do not meet the case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive years.

(K) QCDR measures with clinician attribution issues, where the quality action is not under the direct control of the reporting clinician.

(L) QCDR measures that focus on rare events or "never events" in the measurement period.

(M) QCDR does not have permission to use a QCDR measure owned by another QCDR for the applicable performance period.

(N) If a QCDR measure owner is not approved or is not in good standing, any associated QCDR measures will not be approved.

(c) *Additional requirements for Health IT vendors.* (1) Beginning with the CY 2021 performance period/2023 MIPS payment year, health IT vendors must be able to submit data for the MIPS performance categories as follows:

(i) Health IT vendors that support MVPs must be able to submit data for all of the MIPS performance categories:

(A) Quality, except:

(1) The CAHPS for MIPS survey; and

(2) QCDR measures;

(B) Improvement activities; and

(C) Promoting Interoperability, if the eligible clinician, group, virtual group, or subgroup is using CEHRT, unless:

(1) The third party intermediary's MIPS eligible clinicians, groups, virtual groups, or subgroups fall under the reweighting policies at § 414.1380(c)(2)(i)(A)(4)(i) through (iii) or (c)(2)(i)(C)(1) through (7) or (c)(2)(i)(C)(9).

(2) [Reserved]

(ii) Health IT vendors that do not support MVPs must be able to submit data for at least one of the MIPS performance categories described in paragraphs (c)(1)(i) of this section.

(iii) Beginning with the CY 2023 performance period/2025 MIPS payment year, Health IT vendors must support MVPs that are applicable to the MVP participant on whose behalf they submit MIPS data. Health IT vendors may also support the APP.

(2) [Reserved]

(d) *Additional requirements for CMS-approved survey vendors.* (1) CMS-approved survey vendors may submit data on the CAHPS for MIPS survey for the MIPS quality performance category.

(2) 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:

(3) 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 data), 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.

(4) 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.

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

(6) 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.

(7) 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.

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

(e) *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, has submitted a false certification under paragraph (a)(3) of this section, or has submitted data that are 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) by a date specified by CMS. The CAP must address the following issues, unless different or additional information is specified by CMS:

(A) The issues that contributed to the non-compliance.

(B) The impact to individual clinicians, groups, virtual groups, subgroups, or APM Entities, regardless of whether they are participating in the program because they are MIPS eligible, voluntarily participating, or opting in to participating in the MIPS program, and any QCDRs that were granted licenses to the measures of a QCDR upon which a CAP has been imposed.

(C) The corrective actions to be implemented by the third party intermediary to ensure that the non-compliance has been resolved and will not recur in the future.

(D) The detailed timeline for achieving compliance with the applicable requirements.

(E) The communication plan for communicating the impact to the parties identified in paragraph (e)(1)(i)(B) of this section.

(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 a third party intermediary 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) A data submission that contains data inaccuracies affecting the third party intermediary's total clinicians may lead to remedial action/termination of the third party intermediary for future program year(s) based on CMS discretion.

(4) For purposes of this paragraph (e), CMS may determine that submitted data are inaccurate, unusable, or otherwise compromised, including but not limited to, if the submitted data:

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

(ii) [Reserved]

(5) Beginning with the CY 2024 performance period/2026 MIPS payment year, a QCDR or qualified registry that submits a participation plan as required under paragraph (b)(3)(viii) of this section, but does not submit MIPS data for the applicable performance period for which they self-nominated under paragraph (b)(3)(viii) of this section, will be terminated.

(f) *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, group, virtual group, subgroup, or APM Entity on behalf of whom it submits data. The contact information must include, at a minimum, the MIPS eligible clinician, group, virtual group, subgroup, or APM Entity 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.

[86 FR 65677, Nov. 19, 2021, as amended at 87 FR 70229, Nov. 18, 2022]

§ 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