

## § 414.1300

CMS to inquire about its report and 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(k)—Quality Reporting System.

(3) Section 1848(m)—Incentive Payments for Quality Reporting.

(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.

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

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

[81 FR 77537, Nov. 4, 2016, as amended at 86 FR 65669, Nov. 19, 2021]

### § 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.

*Aligned Other Payer Medical Home Model* means an aligned other payer payment arrangement (not including a Medicaid payment arrangement) operated by a payer formally partnering in a CMS Multi-Payer Model that is a Medical Home Model through a written expression of alignment and cooperation, such as a memorandum of understanding (MOU) with CMS, and is determined by CMS to have the following characteristics:

(1) The other payer 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 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).

*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, subgroup, or group may submit the required data for the Promoting Interoperability 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

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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).

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(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 Promoting Interoperability 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, or subsequent Base EHR definition (as defined in 45 CFR 170.102), and has been certified to the ONC health IT certification criteria as adopted and updated in 45 CFR 170.315—

(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 MIPS 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.

(3) For purposes of determinations under §§414.1415 and 414.1420, beginning for CY 2024, EHR technology (which could include multiple technologies) certified under the ONC Health IT Certification Program that meets—

(i) The 2015 Edition Base EHR definition, or subsequent Base EHR definition (as defined in 45 CFR 170.102); and

(ii) Any such ONC health IT certification criteria adopted or updated in 45 CFR 170.315 that are determined applicable for the APM, for the year, considering factors such as clinical practice area, promotion of interoperability, relevance to reporting on applicable quality measures, clinical care delivery objectives of the APM, or any other factor relevant to documenting and communicating clinical care to patients or their health care providers in the APM.

*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 (except as provided in paragraph (1) of this definition, for the CY 2017 through CY 2022 performance periods/2019 through 2024 MIPS payment years); the CAHPS for MIPS survey measure; administrative claims measures; and Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs).

*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(l)(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 group* means a group that CMS determines meets the criteria specified in § 414.1380(e)(2)(ii).

*Facility-based MIPS eligible clinician* means an individual MIPS eligible clinician who CMS determines meets the criteria specified in § 414.1380(e)(2)(i).

*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.

*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 an outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, opioid, or health equity-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 per-

formance period as specified by CMS; and

(2) For 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; and

(3) Beginning with the 2022 MIPS payment year, an individual 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, 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 hospital-based individual MIPS eligible clinician during 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) For the 2021 and 2022 MIPS payment years, 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.

(5) Beginning with the 2023 MIPS payment year, the low-volume threshold that applies to an individual eligible clinician, or 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.

*Meaningful EHR user for MIPS* means a MIPS eligible clinician that possesses CEHRT, uses the functionality of CEHRT, reports on applicable objectives and measures specified for the Promoting Interoperability performance category for a performance period in the form and manner specified by CMS, does not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of CEHRT, and engages in activities related to supporting providers with the performance of CEHRT. In addition, a MIPS eligible clinician (other than a qualified audiologist) is not a meaningful EHR user for a performance period if the HHS Inspector General refers a determination that the MIPS eligible clinician committed information blocking as defined at 45 CFR 171.103 during the calendar year of the performance period. The term “information blocking,” with respect to an individual MIPS eligible clinician or group, shall not include an act or practice other than an act or practice committed by such individual MIPS eligible clinician or group.

*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:

(1) For the 2019 through 2022 MIPS payment years, an APM that meets the criteria specified under § 414.1370(b).

(2) Beginning with the 2023 MIPS payment year, an APM that meets the criteria as set forth in § 414.1367(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, as applicable, 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 through 2023 MIPS payment 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 dietitian or nutrition professional; and

(vii) A group that includes such clinicians.

(3) For the 2024 MIPS payment year and future years:

(i) A clinician described in paragraph (2) of this definition;

(ii) A clinical social worker (as defined in section 1861(hh)(1) of the Act);

(iii) A certified nurse midwife (as defined in section 1861(gg)(2) of the Act); and

(iv) 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.

*MIPS Value Pathway* means a subset of measures and activities established through rulemaking.

*Multispecialty group* means a group as defined at §414.1305 that consists of two or more specialty types as determined by CMS using Medicare Part B claims.

*MVP participant* means an individual MIPS eligible clinician, multispecialty group, single-specialty group, subgroup, or APM Entity that is assessed on an MVP in accordance with §414.1365 for all MIPS performance categories. For the CY 2026 performance period/2028 MIPS payment year and future years, MVP Participant means an individual MIPS eligible clinician, single-specialty group, subgroup, or APM Entity that is assessed on an MVP in accordance with §414.1365 for all MIPS performance categories.

*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.

*Physician Compare* means the Physician Compare internet website of the Centers for Medicare & Medicaid Services (or a successor website).

*Population health measure* means a quality measure that indicates the quality of a population or cohort's overall health and well-being, such as access to care, clinical outcomes, coordination of care and community services, health behaviors, preventive care and screening, health equity, or utilization of health services.

*Primary care services* for purposes of CMS Web Interface and CAHPS for MIPS survey beneficiary assignment means the set of services identified by the following:

(1) CPT codes:

(i) 99201 through 99215 (codes for office or other outpatient visit for the evaluation and management of a patient); 99304 through 99318 (codes for professional services furnished in a

nursing facility, excluding professional services furnished in a SNF for claims identified by place of service (POS) modifier 31); 99319 through 99340 (codes for patient domiciliary, rest home, or custodial care visit); 99341 through 99350 (codes for evaluation and management services furnished in a patient's home for claims identified by POS modifier 12); 99487, 99489, and 99490 (codes for chronic care management); and 99495 and 99496 (codes for transitional care management services); and

(ii) Beginning with the 2023 MIPS payment year, 99421, 99422, and 99423 (codes for online digital evaluation and management services (e-visit)); 99441, 99442, and 99443 (codes for telephone evaluation and management services); and 96160 and 96161 (codes for administration of health risk assessment).

(2) HCPCS codes:

(i) G0402 (code for the Welcome to Medicare visit); and G0438 and G0439 (codes for the annual wellness visits); and

(ii) Beginning with the 2023 MIPS payment year, G2010 (code for remote evaluation of patient video/images); and G2012 (code for virtual check-in).

*QCDR measure* means a quality measure that is submitted by a QCDR and approved by CMS under §414.1400. QCDR measures consist of:

(1) 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

(2) 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.

*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 posting* means the document made available that lists qualified registries or QCDRs available by CMS for use by MIPS eligible clinicians, groups, subgroups, virtual groups, and APM Entities.

*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

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§ 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 by the Federal Office of Rural Health Policy (FORHP), using the most recent FORHP Eligible ZIP Code file available.

*Single specialty group* means a group as defined at § 414.1305 that consists of one specialty type as determined by CMS using Medicare Part B claims.

*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).

*Special status* means that a MIPS eligible clinician:

(1) Meets the definition of an ASC-based MIPS eligible clinician, facility-based MIPS eligible clinician, hospital-based MIPS eligible clinician, non-patient facing MIPS eligible clinician, or is in a small practice; or

(2) Is located in an HPSA or rural area.

*Subgroup* means a subset of a group which contains at least one MIPS eligible clinician and is identified by a combination of the group TIN, subgroup identifier, and each eligible clinician's NPI.

*Submission type* means the mechanism by which the submitter type submits data to CMS, including, but not limited to:

- (1) Direct;
- (2) Log in and upload;
- (3) Log in and attest;
- (4) Medicare Part B claims; and

(5) CMS Web Interface (except as provided in paragraph (5)(i) of this definition, for the CY 2017 through CY 2022 performance periods/2019 through 2024 MIPS payment years).

(i) For the CY 2021 through CY 2024 performance periods/2023 through 2026 MIPS payment years, submission types include the CMS Web Interface for APM Entities reporting through the APM Performance Pathway in accordance with § 414.1367.

(ii) [Reserved]

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

*Third party intermediary* means an entity that CMS has approved under § 414.1400 to submit data on behalf of a MIPS eligible clinician, group, virtual group, subgroup, or APM Entity 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; 84 FR 63194, Nov. 15, 2019; 85 FR 54872, Sept. 2, 2020; 85 FR 85029, Dec. 28, 2020; 86 FR 65670, Nov. 19, 2021; 86 FR 73159, Dec. 27, 2021; 87 FR 70227, Nov. 18, 2022; 88 FR 79533, Nov. 16, 2023; 89 FR 54716, July 1, 2024]