

§ 414.1350

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of payer for MIPS payment years 2020 and 2021.

(3) At least 70 percent of the MIPS eligible clinician, group, and virtual group's patients that meet the measure's denominator criteria, regardless of payer for MIPS payment years 2022, 2023, 2024, and 2025.

(i) Applicable to an APM Entity for MIPS payment years 2023, 2024, and 2025.

(ii) Applicable to a subgroup for MIPS payment year 2025.

(4) At least 75 percent of the MIPS eligible clinician, group, virtual group, subgroup, and APM Entity's patients that meet the measure's denominator criteria, regardless of payer for MIPS payment years 2026, 2027, and 2028.

(b) MIPS eligible clinicians, groups, virtual groups, subgroups, and APM Entities 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.

(i) Applicable to virtual groups starting with MIPS payment year 2020.

(ii) [Reserved]

(3) At least 70 percent of the applicable Medicare Part B patients seen during the performance period to which the measure applies for MIPS payment years 2022, 2023, 2024, and 2025.

(i) Applicable to APM Entities starting with MIPS payment year 2023 and subgroups starting with MIPS payment year 2025.

(ii) [Reserved].

(4) At least 75 percent of the applicable Medicare Part B patients seen during the performance period to which the measure applies for MIPS payment years 2026, 2027, and 2028.

(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]

(d) APM Entities, specifically Medicare Shared Savings Program Accountable Care Organizations meeting reporting requirements under the APP, submitting quality measure data on Medicare CQMs must submit data on:

(1) At least 75 percent of the applicable beneficiaries eligible for the Medicare CQM, as defined at § 425.20, who meet the measure's denominator criteria for MIPS payment years 2026, 2027, and 2028.

(2) [Reserved]

(e) If quality data are submitted selectively such that the submitted data are unrepresentative of a MIPS eligible clinician, group, virtual group, subgroup, or APM Entity's performance, any such data would not be true, accurate, or complete for purposes of § 414.1390(b) or § 414.1400(a)(5).

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53953, Nov. 16, 2017; 83 FR 60079, Nov. 23, 2018; 84 FR 63195, Nov. 15, 2019; 86 FR 65671, Nov. 19, 2021; 87 FR 70227, Nov. 18, 2022; 88 FR 79534, Nov. 16, 2023]

§ 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 for the 2017 through 2019 performance periods.

(2) For the total per capita cost measure specified for the 2017 through 2019 performance periods, 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 clinician (MSPB clinician) measure specified for the 2017 through 2019 performance periods, 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 clinician 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 for 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 for 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.

(8) Beginning with the 2020 performance period, each cost measure is attributed according to the measure specifications for the applicable performance period.

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

(2) For the Medicare spending per beneficiary clinician 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 and after the CY 2019 performance period/2021 MIPS payment year, the case minimum is 10, unless otherwise specified for individual measures. Beginning

with the CY 2022 performance period/2024 MIPS payment year, the case minimum for Colon and Rectal Resection procedural episode-based measure is 20 episodes.

(5) For the acute inpatient medical condition episode-based measures specified beginning with and after CY 2019 performance period/2021 MIPS payment year, the case minimum is 20, unless otherwise specified for individual measures.

(6) For the chronic condition episode-based measures specified beginning with and after the CY 2022 performance period/2024 MIPS payment year, the case minimum is 20, unless otherwise specified for individual measures.

(7) For the care setting episode-based measures specified beginning with and after the CY 2024 performance period/2026 MIPS payment year, the case minimum is 20, unless otherwise specified for individual measures.

(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 years 2021 and 2022.

(4) 20 percent of the MIPS final score for MIPS payment year 2023.

(5) 30 percent of the MIPS final score for MIPS payment year 2024 and each subsequent MIPS payment year.

[83 FR 60079, Nov. 23, 2018, as amended at 84 FR 63195, Nov. 15, 2019; 85 FR 85031, Dec. 28, 2020; 86 FR 65671, Nov. 19, 2021; 88 FR 79535, Nov. 16, 2023]

§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