

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.

(7) The performance threshold for the 2022 MIPS payment year is 45 points.

(8) The performance threshold for the 2023 MIPS payment year is 60 points.

(9) Pursuant to the methodology established at paragraph (g) of this section:

(i) The performance threshold for the 2024 MIPS payment year is 75 points. The prior period used to determine the performance threshold is the 2019 MIPS payment year.

(ii) The performance threshold for the 2025 MIPS payment year is 75 points. The prior period used to determine the performance threshold is the 2019 MIPS payment year.

(iii) The performance threshold for the 2026 MIPS payment year is 75 points. The prior period to determine the performance threshold is the 2019 MIPS payment year.

(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.

(6) The additional performance threshold for the 2022 and 2023 MIPS payment years is 85 points.

(7) The additional performance threshold for the 2024 MIPS payment year is 89 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.* Beginning with 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.

(g) *Performance threshold methodology.* For each of the 2024, 2025, and 2026 MIPS payment years, the performance threshold is the mean of the final scores for all MIPS eligible clinicians from a prior period as specified under paragraph (b) of this section.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53960, Nov. 16, 2017; 83 FR 60089, Nov. 23, 2018; 84 FR 63200, Nov. 15, 2019; 86 FR 65681, Nov. 19, 2021; 87 FR 70229, Nov. 18, 2022; 88 FR 79538, Nov. 16, 2023; 89 FR 9784, Feb. 12, 2024]

§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) For QP Performance Periods ending with 2018, require at least 50 percent, or for QP Performance Periods beginning with 2019 and ending with 2024, 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;

(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; and

(iii) For QP Performance Periods beginning with 2025, require use of CEHRT as defined at paragraph (3) under CEHRT at §414.1305.

(2) [Reserved].

(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 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 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) The quality measures upon which an Advanced APM bases the payment in paragraph (b)(1) of this section must include at least one 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.

(4) A single quality measure that meets the criteria under both paragraphs (b)(2) and (3) of this section may be used to satisfy the requirements of paragraph (b)(1) of this section.

(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 2023, 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