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Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstances Policy for the Transition Year
[CMS-5522-FC and IFC]

Summary of Final Rule

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I. Introduction and Background

On November 2, 2017 the Centers for Medicare & Medicaid Services (CMS) placed on public display a final rule with comment period establishing updates to the Quality Payment Program (QPP) for 2018, QPP Year 2. The QPP is composed of 2 tracks: (1) The Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (APMs). The final rule is slated for publication in the November 16, 2017 issue of the *Federal Register*.

In addition, CMS displayed an interim final rule with comment period (IFC) that addresses extreme and uncontrollable circumstances MIPS eligible clinicians may face as a result of widespread catastrophic events affecting a region of locale in 2017, such as Hurricanes Irma, Harvey, and Maria.

The policies in this final rule generally will take effect on January 1, 2018.

In the final rule, CMS finalizes some modifications to the four MIPS performance categories: Quality, Cost, Improvement Activities, and Advancing Care Information (ACI). For QPP Year 2, the performance period will be 2018 and the payment adjustments under MIPS will be made in 2020. (In this summary all references to years are calendar years unless otherwise noted.) For the 2018 performance year final score, the following weights will apply for the performance categories: 50 percent for quality, 10 percent for cost, 15 percent for improvement activities and 25 percent for ACI. CMS also finalizes the requirements for Virtual Groups and allows for Virtual Groups to participate in the 2018 performance period.

With respect to APMs, CMS retains with minor changes many of the policies it finalized for the transition year regarding Advanced APM standards and determinations of Qualifying Participant status (QPs) for MIPS eligible clinicians under the Medicare and All-Payer Combination options. CMS finalizes changes including extending the revenue-based nominal amount standard for two additional years, and phasing-in the nominal amount standard required for Medical Home Models more slowly. CMS details how the All-Payer Combination Option will be implemented; updated provisions include finalizing a single QP Performance Period definition (January-August annually) and describing further how QP determinations will be made. CMS finalizes making All-Payer Combination Option QP determinations at either the individual or APM entity level, rather than only at the individual level as proposed.

CMS estimates that more than one-third of the nearly 1.5 million clinicians billing to Part B (621,700) will be assigned a MIPS score for 2020 because others will be ineligible for or excluded from MIPS. An estimated 540,347 clinicians will be excluded under the low-volume exclusion; 233,289 clinicians are in excluded specialties; and 81,954 due to the exclusion for newly enrolled clinicians. Based on APMs operating in 2017, CMS estimates 70,732 qualifying APM participants (and thus excluded from MIPS) will receive total associated incentive payment amounts that range from \$675 million to \$900 million.

For 2020, CMS estimates that it will distribute about \$118 million in payment adjustments on a budget neutral basis. This total excludes the additional \$500 million available under MACRA for exceptional performance payments. CMS estimates that 97 percent of eligible clinicians will have a positive or neutral payment adjustment and 3.0 percent will have a negative payment adjustment. These proportions vary by specialty and practice size. CMS estimates that approximately 185,000 to 250,000 clinicians will become QPs for the 2020 payment year based on estimates of Advanced APM participation.

II. Provisions of the Final Regulations and Analysis of and Responses to Comments

A. MIPS Program Details

1. MIPS Eligible Clinicians

a. Definition of a MIPS Eligible Clinician

In the 2017 QPP final rule, CMS finalized the following:

- Defines a MIPS eligible clinician as a physician (as defined in section 1861(r)¹ of the Act), a physician assistant (PA), nurse practitioner (NP), and clinical nurse specialist (CNS), a certified registered nurse anesthetist (CRNA), and a group that includes such clinicians.
- To exclude Qualifying APM Participants (QPs), Partial Qualifying APM participants (Partial QPs) who choose not to report data under MIPS, low-volume threshold eligible clinicians, and new Medicare-enrolled eligible clinicians from the definition of a MIPS eligible clinician per the statutory exclusions.

CMS finalized that eligible clinicians who are not MIPS eligible clinicians have the option to voluntarily report measures and activities for MIPS. CMS finalized that these clinicians, who voluntarily report on applicable measures and activities specified under MIPS, will not receive an adjustment under MIPS.

The MIPS payment adjustment applies only to the amount otherwise paid under Part B for items and services furnished by MIPS eligible clinicians during the year in which the MIPS payment adjustment is applied.

b. Group Practice

In the 2017 QPP final rule, CMS defined a group as a single Taxpayer Identification Number (TIN) with two or more eligible clinicians (including at least one MIPS eligible clinician) as identified by their NPIs, who have assigned their Medicare billing rights to the TIN. CMS also defined an APM Entity group as a group of eligible clinicians participating in an APM Entity, as identified by a combination of the APM identifier, APM Entity identifier, TIN, and NPI for each participating eligible clinician.

CMS clarifies it considers a group to be either an entire TIN or the portion of a TIN that: (1) is participating in MIPS according to the generally applicable scoring criteria while the remaining portion of the TIN is participating in an MIPS APM or an Advanced APM according to the APM scoring standard; and (2) chooses to participate in MIPS at the group level. Groups without at least one APM participant are not permitted to “split” TINs.

¹ Physicians are defined in section 1861(r) of the Act to include doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors.

c. Small Practices

For 2018, CMS is modifying the definition of a small practice to mean a practice consisting of 15 or fewer eligible clinicians.

For performance periods occurring in 2018 and future years, CMS finalizes its proposal to determine the size of small practices by utilizing claims data. Specifically, CMS finalizes a “small practice determination period” as a 12-month assessment period, which consists of an analysis of claims data that spans from the last 4 months of a year 2 years prior to the performance period followed by the first 8 months of the next year and includes a 30-day claims run out. For purposes of performance periods occurring in 2018 (2020 MIPS payment year), CMS will identify small practices based on 12 months of data starting from September 1, 2016 to August 31, 2017. CMS will not change an eligibility determination once the determination is made for a given performance period.

d. Rural Area and Health Professional Shortage Area (HPSA) Practices

For the 2017 performance period, CMS considers an individual MIPS eligible clinician or a group with at least one practice site under its TIN in a ZIP code designated as a rural area or HPSA to be a rural area or HPSA practice.

For the 2018 performance period and future years, CMS finalizes its proposal to use a higher standard. CMS finalizes the definition of rural areas as ZIP codes designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data set available. For performance periods occurring in 2018 and future years, an individual MIPS eligible clinician, a group, or a virtual practice with multiple practices under its TINs or TINs within a virtual group would be designated as a rural or HPSA practice only if more than 75 percent of NPIs billing under the individual MIPS eligible clinician’s or group’s TIN or within a virtual group, as applicable, are located in a ZIP code designated as a rural area or HPSA.

CMS notes that if a clinician practices at multiple sites having different TINs, each TIN would have a separate rural analysis applied for that particular site (TIN).

e. Non-Patient Facing MIPS Eligible Clinicians

For the 2018 performance period and future years, CMS finalizes the definition of a non-patient facing MIPS eligible clinician at §414.1305 to mean:

- An individual clinician that bills 100 or fewer patient-facing encounters (including Medicare telehealth services during the non-patient facing determination period; and
- A group or a virtual group provided that more than 75 percent of the NPIs billing under the group’s TIN or within a virtual group, as applicable, meets the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period.

For the 2018 performance period, CMS will initially identify individuals and groups who are considered non-patient facing MIPS eligible clinicians based on 12 months of data starting from September 1, 2016 to August 31, 2017. The second determination period will be based on data starting from September 1, 2017 to August 31, 2018. CMS will not change the non-patient facing status of any individual MIPS eligible clinician or group identified as non-patient facing during the first eligibility determination analysis based on the second eligibility determination analysis.

For 2018, CMS finalized that groups considered non-patient facing will have their ACI performance category automatically reweighted to zero. CMS will apply these policies for purposes of the 2020 payment year and future years.

f. MIPS Eligible Clinicians Who Practice In Critical Access Hospitals (CAHs) Billing Under Method II (Method II CAHs)

In this QPP proposed rule, CMS reiterates its policy from the 2017 QPP final rule. In the 2017 QPP final rule, CMS stated that MIPS eligible clinicians who practice in CAHs that bill under Method I (Method I CAHs) would have the MIPS payment adjustment apply to payments made for items and services billed by these clinicians under the Physician Fee Schedule (PFS). The MIPS adjustment will not apply to the facility payment to the CAH.

In addition, MIPS eligible clinicians who practice in Method II CAHs and have not assigned their billing rights to the CAH will have the MIPS payment adjustment also apply to payments made for items and services, similar to MIPS eligible clinicians who practice in Method I CAHs. For MIPS eligible clinicians who practice in Method II CAHs and have assigned their billing rights to the CAH, the MIPS payment adjustment will apply to Method II CAH payments.

g. MIPS Eligible Clinicians Who Practice In RHCs and/or FQHCs

As established in the 2017 QPP final rule, services provided by a MIPS eligible clinician that are payable under the RHC or FQHC methodology, will not be subject to the MIPS payment adjustments.

h. MIPS Eligible Clinicians Who Practice in Ambulatory Surgical Centers (ASCs), Home Health Agencies (HHAs), Hospice, and Hospital Outpatient Departments (HOPDs)

CMS notes that if a MIPS eligible clinician furnishes items and services in an ASC, HHA, Hospice, and/or HOPD and the facility bills for those items and services (including prescription drugs) under the facility's all-inclusive payment methodology or prospective payment system methodology, the MIPS adjustment would not apply to the facility payment. If a MIPS eligible clinician furnishes other items and services in these setting and bills separately for them under the PFS, the MIPS adjustment would apply to these payments. These items and services that are separately billed would also contribute to the determination of the low-volume threshold.

CMS finalizes its proposal that services rendered by an eligible clinician that are payable under the ASC, HHA, Hospice or HOPD methodology would not be subject to the MIPS payment adjustments. These eligible clinicians have the option to voluntarily report on applicable

measures and activities; the data received will not be used to assess their performance for the purpose of the MIPS adjustment. CMS notes that eligible clinicians who bill both under the PFS and one of these other billing methodologies may be required to participate in MIPS if they exceed the low-volume threshold and are otherwise eligible clinicians. In these cases, the data reported will be used to determine their MIPS payment adjustment.

2. Exclusions

a. New Medicare-Enrolled Eligible Clinician

In the 2017 QPP final rule, CMS defined a new Medicare-enrolled eligible clinician as a professional who first becomes a Medicare-enrolled eligible clinician within the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) during the performance period for a year and had not previously submitted claims as a Medicare-enrolled eligible clinician as an individual, an entity, or a part of a physician group or under a different billing number or tax identifier. CMS also established that in no case would a MIPS payment adjustment factor apply to items and services provided by new Medicare-enrolled eligible clinicians.

b. Qualifying APM Participant (QP) and Partial Qualifying APM Participant (Partial QP)

The definition of a MIPS eligible clinician does not include, for a year, an eligible clinician who is a QP or a Partial QP who does not report on the applicable measures and activities that are required under MIPS. Consistent with the statute, CMS' definition of a MIPS eligible clinician does not include QPs and Partial QPs who do not report on applicable measures and activities that are required to be reported under MIPS for any given performance period.

c. Low-Volume Threshold

CMS finalizes its proposal to define an individual MIPS eligible clinician or group who do not exceed the low-volume threshold as an individual MIPS eligible clinician or group who, during the performance period, has Medicare billing charges less than or equal to \$90,000 or provides care for 200 or fewer Part B-enrolled Medicare beneficiaries.

For the 2018 payment period, CMS will initially identify individuals and groups who are considered low-volume MIPS eligible clinicians based on 12 months of data starting from September 1, 2016 to August 31, 2017. The second determination period will be based on data starting from September 1, 2017 to August 31, 2018. CMS will not change the low-volume status of any individual MIPS eligible clinician or group identified as low-volume during the first eligibility determination analysis based on the second eligibility determination analysis.

3. Group Reporting

CMS notes that group size is determined before exclusions are applied. Group size determination is based on the number of NPIs associated with a TIN, which would include clinicians (NPIs) who may be excluded from MIPS participation and do not meet the definition of a MIPS eligible clinician.

4. Virtual Groups

a. Definition of a Virtual Group

CMS finalizes with modifications the following proposed definitions at §414.1305:

- A solo practitioner is a practice consisting of one eligible clinician (who is also a MIPS eligible clinician).
- A virtual group is a combination of two or more TINs assigned to one or more solo practitioners or one or more groups with 10 or fewer eligible clinicians, or both that elects to form a virtual group for a performance period for a year. A group would need to include one MIPS eligible clinician in order to be eligible to join or form a virtual group.

Although the entire TIN participates in a virtual group, including each NPI under a TIN, and are assessed and scored collectively as a virtual group, only NPIs that meet the definition of a MIPS eligible clinician would be subject to a MIPS payment adjustment. For groups other than groups containing participants in a MIPS APM or an Advanced APM, each MIPS eligible clinician (TIN/NPI) would receive a MIPS adjustment based on the virtual group's combined performance assessment (combination of TINs).

CMS notes that the policies applicable to MIPS payment adjustment for groups containing participants in a MIPS APM or an Advanced APM also apply to virtual groups. Specifically, for virtual groups, CMS finalizes the following:

- The portion of the virtual group that is being scored according to the generally applicable scoring criteria (TIN/NPI) would receive a MIPS adjustment based on the entire virtual group's combined performance assessment (combination of TINs);
- CMS will use waiver authority to ensure that virtual group members who are participating in a MIPS APM would receive their payment adjustment based on their score under the APM scoring standard (TIN/NPI) (discussed in section II.A.6.g of this summary); and
- The portion of the virtual group that achieves QP or Partial QP status may be exempt from MIPS.

b. MIPS Virtual Group Identifier for Performance

CMS finalizes its proposal that each MIPS eligible clinician who is part of a virtual group will be identified by a unique virtual group participant identifier which will be a combination of three identifiers: (1) virtual group identifier (established by CMS), (2) TIN, and (3) NPI.

CMS intends to notify virtual groups of their official status as close to the start of the performance period as technically feasible. CMS notes that virtual groups will need to provide their virtual group identifiers to third party intermediaries that will be submitting their performance data. Virtual groups that elect to participate in MIPS via the CMS Web Interface or administer the CAHPS for MIPS survey, will register via the CMS Web Interface. CMS intends to update submission specifications prior to the start of the applicable submission period.

c. Application of MIPS Group Policies to Virtual Groups

CMS finalizes its proposal to apply previously finalized and proposed group related policies to virtual groups, unless otherwise specified. CMS finalizes its proposed modification of the definition of both a non-patient facing MIPS eligible clinician and its small practice, rural and HPSA designations.

- **Non-patient facing:** The definition of a non-patient facing MIPS eligible clinician includes a virtual group provided that more than 75 percent of the NPIs billing under the virtual group's TINs meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period.
- **Small practice:** A virtual group would be identified as having a small practice status if the virtual group consists of 15 or fewer eligible clinicians (NPIs).
- **Rural area and HPSA practices:** A virtual group with 75 percent or more of the NPIs billing under the virtual group's TINs are in a ZIP code as a rural area or HPSA will be designated as a rural area or HPSA practice at the virtual group level.

CMS is also finalizing that a virtual group will be considered a certified or recognized patient-centered medical home (PCMH) or comparable specialty practice if at least 50 percent of the practice sites within the TINs are certified or recognized as a PCMH or comparable specialty practice.

CMS notes that the measures and activities available to groups would also be available to virtual groups. Virtual groups are required to meet all the reporting requirements and the virtual group is responsible for ensuring that their measures and activities are aggregated across the virtual group (across their TINs). The performance feedback for virtual groups will be similar to feedback reports for groups, which is based on the performance of the entire group for each performance category.

CMS states that for purposes of the ACI performance category, the policies pertaining to groups will apply to virtual groups. For all virtual group reporting, the virtual group will need to aggregate data for all of the individual MIPS eligible clinicians within the virtual group for which its TINs have data in CEHRT. The virtual group will submit the data that its TINs have based on utilization of CEHRT and exclude data not collected from a non-certified EHR system.

For the ACI performance category, only those data contained in CEHRT should be reported. CMS notes that when aggregating performance on ACI measures for virtual group level reporting, it will not require that a virtual group determine that a patient seen by one MIPS eligible clinician is not also seen by another MIPS eligible clinician in the TIN that is part of the virtual group or captured in a different CEHRT system. CMS provides virtual groups some flexibility for counting unique patients in the denominators for ACI measures to accommodate situations where data aggregation may be hindered by system capabilities across multiple CEHRT platforms.

d. Election Process

CMS finalizes the following:

Eligibility. A solo practitioner or a group of 10 or fewer eligible clinicians must make their election prior to the start of the applicable performance period and cannot change their election during the performance period. Virtual group participants may elect to be in only one virtual group for a performance period, and, in the case of a group, the election applies to all MIPS eligible clinicians in the group.

Election Deadline. A virtual group representative must make an election, on behalf of the members of a virtual group, regarding the formation of a virtual group for an applicable period, by December 31 of the year preceding the applicable period. CMS intends to publish the beginning date of the virtual group election period applicable to the 2018 performance period and future years in subregulatory guidance.

CMS intends to make technical assistance (TA) available to support clinicians who choose to form a virtual group. For QPP year 3, if technically feasible, CMS intends to provide an electronic election process.

Election Process. There will be a two-stage virtual group election process for the 2018 and 2019 performance period. Stage 1 is optional for the 2018 and 2019 performance period. CMS states that engaging in stage 1 will provide solo practitioners and groups with the option to confirm whether or not they are eligible to form a virtual group before expending resources necessary to become a virtual group.

Stage 1: Virtual Group Eligibility Determination

CMS finalizes the proposal that solo practitioners and groups with 10 or fewer eligible clinicians interested in forming or joining a virtual group will have the option to contact their designated TA representative or the QPP Service Center to obtain information pertaining to virtual groups. Solo practitioners and groups will also contact their designated TA representative or the QPP Service Center to determine whether or not they are eligible, as it relates to the practice size requirement, to participate as a virtual group.

CMS defines a “virtual group eligibility determination period” as the analysis of claims data during an assessment period of up to five months that begins on July 1 and ends as late as November 30 of a year prior to the performance year and includes a 30-day claims run out. CMS notes that an eligibility determination regarding TIN size will be based on a relative point in time within the five-month virtual group eligibility determination period, and not an eligibility determination made at the end of the five-month determination period. TIN size determinations are based on the number of NPIs associated with a TIN, which would include clinicians (NPIs) excluded from MIPS participation and who do not meet the definition of a MIPS eligible clinician.

CMS states that if at any time a TIN was determined to be eligible to participate in a virtual group, the TIN will retain that status for the duration of the election period and the applicable performance period. CMS provides an example that if a group contacted their designated TA

representative or QPP Service Center on November 20, 2017, the claims data analysis would include the months of July through October 2017. The TIN size that was determined on November 20, 2017 will be retained for the duration of the election period and the 2018 performance period.

Stage 2: Virtual Group Formation

CMS finalizes the following proposals:

(i) TINs comprising a virtual group must establish a written formal agreement between each member of a virtual group prior to an election.

(ii) On behalf of a virtual group, the official designated virtual group representative must submit an election by December 31 (instead of the proposed date of December 1) of the calendar year prior to the start of the applicable performance period. The election for the 2018 and 2019 performance periods will occur via e-mail to the QPP Service Center at MIPS_VirtualGroups@cms.hhs.gov.

(iii) The submission of a virtual group election must include, at a minimum, information pertaining to each TIN and NPI associated with the virtual group and contact information for the virtual group representative.

A virtual group representative will submit the following types of information:

- Each TIN associated with the virtual group;
- Each NPI associated with a TIN that is part of the virtual group;
- The name of the virtual group representative;
- The affiliation of the virtual group representative;
- Contact information for the virtual group representative; and
- Confirmation that a written formal agreement has been established between each member of the virtual group prior to election and that each member is aware of participating in MIPS as a virtual group for an applicable performance period.

CMS notes that each member of the virtual group must retain a copy of the virtual group's written agreement. In addition, the virtual group agreement is subject to the MIPS data validation and auditing requirements.

(iv) Once an election is made, the virtual group representative must contact their designated CMS contact to update any election information that changed during a performance period prior to the start of an applicable submission period. Virtual groups will use the QPP Service Center as their designated CMS contact; CMS will define this further in subregulatory guidance.

CMS will contact the official designated virtual group representative via email to notify the group of its official virtual group status and issue a virtual group identifier for submission of performance data during the submission period.

To provide sufficient time to form a virtual group prior to the start of the 2018 performance period, CMS provided virtual groups an opportunity to make an election prior to the publication

of the final rule. The election period began on October 11, 2017 and CMS issued related information via subregulatory guidance.² *Virtual groups will have from October 11, 2017 to December 31, 2017 to make an election for the 2018 performance period.*

CMS acknowledges that the size of a group may fluctuate during a performance period. For groups within a virtual group that are determined to have a group size of 10 eligible clinicians or less, based on the one time determination per applicable performance year, any new eligible clinicians or MIPS eligible clinicians that join the group during the performance period will participate in MIPS as part of the virtual group. The virtual group representative needs to contact the QPP Service Center to update the information. Virtual groups must re-register before each performance period.

CMS notes that the statute specifies that a virtual group election cannot be changed during the performance period.

e. Virtual Group Agreements

CMS finalizes with modifications the proposals regarding virtual group agreements. CMS finalizes that virtual groups must execute a formal written agreement between each member of a virtual group that includes the following elements:

- Identifies the parties to the agreement by name of party, TIN, and NPI and includes as parties to the agreement only the groups and solo practitioners that comprise the virtual group.
- Is executed on behalf of each party by an individual who is authorized to bind the party.
- Expressly requires each member of the virtual group (including each NPI under each TIN) to agree to participate in the MIPS as a virtual group and comply with the requirements of the MIPS and all other applicable laws and regulations (including, but not limited to, federal criminal law, False Claims Act, anti-kickback statute, civil monetary penalties law, Health Insurance Portability and Accountability Act, and physician self-referral law).
- Identifies each NPI under each TIN in the virtual group and requires each TIN within a virtual group to notify all NPIs associated with the TIN of their participation in the MIPS as a virtual group.
- Sets forth the NPI's rights and obligations in, and representation by, the virtual group, including without limitation, the reporting requirements and how participation in the MIPS as a virtual group affects the ability of the NPI to participate in MIPS outside of the virtual group.

² The subregulatory guidance can be accessed at <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html>.

- Describes how the opportunity to receive payment adjustments will encourage each member of the virtual group (including each NPI under each TIN) to adhere to quality assurance and improvement.
- Require each party of the agreement to update its Medicare enrollment information, including the addition and deletion of NPIs billing through its TIN, on a timely basis in accordance with Medicare program requirements and to notify the virtual group of any such changes within 30 days after the change.
- Is for a term of at least one performance period as specified in the formal written agreement.
- Requires completion of a close-out process upon termination or expiration of the agreement that requires each party of the virtual group agreement to furnish, in accordance with applicable privacy and security laws, all data necessary in order for the virtual group to aggregate its data across the virtual group.

Commenters expressed concerns about the prohibition of third parties from becoming parties to a virtual group agreement for a variety of reasons, including that independent practice associations (IPAs) could serve as the administrator of a virtual group by collecting and submitting the data on behalf of the virtual group. CMS disagrees and notes that virtual groups are not precluded from utilizing or executing separate agreements with third parties to provide support for virtual group implementation.

Depending on the parties to an existing contract, freestanding virtual group agreements may not be necessary and the required provisions of a virtual group agreement could be included as an addendum to an existing contract, as long as all the requirements are satisfied prior to the applicable performance period. CMS notes, however, that if the existing contract is with a third party intermediary and does not include each TIN within the virtual group, the virtual group agreement could not be effectuated as an addendum to the existing contract.

In response to commenters' suggestions for additional requirements for the formal written agreement, CMS states that virtual groups have the flexibility to identify additional requirements. The model agreement is only a template that virtual groups could utilize. (The model agreement is available at <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html>.) CMS clarifies that virtual groups have the flexibility to establish a new agreement or renew the execution of an existing agreement for the preceding applicable performance period.

CMS states that nothing in this final rule changes the application of the physician self-referral law, anti-kickback statute, or anti-trust laws. CMS notes that a "group practice" as defined for purposes of the physician self-referral law is separate and distinct from a "virtual group" as defined in this final rule.

f. Reporting Requirements

CMS finalizes its proposed reporting requirements for TINs participating in MIPS as virtual groups:

- Individual eligible clinicians and individual MIPS eligible clinicians who are part of a TIN participating at the virtual group level will have their performance assessed as a virtual group.
- Individual eligible clinicians and individual MIPS eligible clinicians who are part of a TIN participating at the virtual group level will need to meet the definition of a virtual group at all times during the performance period for the MIPS payment year.
- Individual eligible clinicians and individual MIPS eligible clinicians who are part of a TIN participating at the virtual group level must aggregate their performance data across multiple TINs in order for their performance to be assessed as a virtual group.
- MIPS eligible clinicians that elect to participate in MIPS at the virtual group level will have their performance assessed at the virtual group level across all four MIPS performance categories.
- Virtual groups will need to adhere to an election process established and required by CMS.

In response to comments about reporting requirements, CMS reiterates that reporting requirements applicable to groups are also generally applicable to virtual groups. However, the requirements for calculating measures and activities reported via QCDRs, qualified registries, EHRs, and attestation differ in their application to virtual groups. Specifically, as summarized below:

- Virtual groups will aggregate data for each NPI under each TIN within the virtual group by adding together the numerators and denominators and then cumulatively collating the data to report one measure ratio at the virtual group level.
- Data completeness requirements for virtual groups apply cumulatively across all TINs in a virtual group. Thus, it is possible that a virtual group cumulatively exceeds the 60 percent data completeness threshold even when one TIN falls below the threshold.
- For the CMS Web Interface and CAHPS for MIPS survey, the sampling methodology will be conducted for each TIN within the virtual group and then cumulatively aggregated across the virtual group; the beneficiary sampling threshold is determined cumulatively as a virtual group.

CMS also reiterates the reporting exceptions applicable to virtual groups:

- If each MIPS eligible clinician within a virtual group faces a significant hardship or has EHR technology that has been decertified, the virtual group can apply for an exception to have its ACI performance category reweighted to zero percent and have its quality performance weight increased to 75 percent.

In response to comments about submission requirements for third party intermediaries such as QCDRs, qualified registries, and EHRs, CMS notes that third party intermediaries need to meet the same requirements established for groups. It intends to include information in its subregulatory guidance for virtual groups and third party intermediaries about data aggregation and submission. In response to a comment about submission of multiple QDRA III files, CMS

states its system does not allow for submission of multiple QDRA III files and groups and virtual groups are required to submit one QDRA III file for each performance category.

CMS also clarifies that if one MIPS eligible clinician (NPI) in a group completes an improvement activity, the entire group (TIN) will receive credit for that activity. Thus, if one MIPS eligible clinician (NPI) in a virtual group completed an improvement activity, the entire virtual group will receive credit for that activity and receive the same score for the improvement activities performance category.

g. Virtual Group Assessment and Scoring

CMS finalizes the following proposals:

- Solo practitioners and groups with 10 or fewer eligible clinicians that have elected to be part of a virtual groups will have their performance measured and aggregated at the virtual group level across all four performance categories.
 - Each TIN/NPI will receive a final score based on the virtual group performance, but the payment adjustment will be applied at the TIN/NPI level.
- For participants in MIPS APMs, CMS will use its authority to waive the requirement that requires performance category scores from virtual group reporting to be used to generate the composite score upon which the MIPS payment adjustment is based for all TIN/NPIs in the virtual group. CMS will use the score assigned to the MIPS eligible clinician based on the applicable APM Entity score to determine MIPS payment adjustments for all MIPS eligible clinicians that are part of an APM Entity participating in a MIPS APM.

CMS notes that MIPS eligible clinicians who are participants in both a virtual group and a MIPS APM will be assessed under MIPS as part of the virtual group and under the APM scoring standard as part of an APM Entity group but will receive their payment adjustment based only on the APM Entity score. An eligible clinician participating in both a virtual group and an Advanced APM who has achieved QP status, will be assessed under MIPS as part of the virtual group but can be excluded from the MIPS payment adjustment because of the QP status.

In response to a comment, CMS clarifies that new Medicare-enrolled eligible clinicians and clinician types not included in the definition of a MIPS eligible clinician who are associated with a TIN that is part of a virtual group will receive a virtual group score but will not receive a MIPS payment adjustment.

5. MIPS Performance Period

In the 2017 QPP final rule, CMS finalized that for the MIPS payment year 2020, the performance period for the:

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

- improvement activities and ACI performance categories for the MIPS payment year 2020, the performance period is a minimum of a continuous 90-day period within 2018, up to and including the entire calendar year.

In the 2017 QPP final rule, CMS also finalized the use of claims with dates of services during the performance period that must be processed no later than 60 days following the close of the performance period for assessing performance and computing the payment adjustment. In addition, CMS finalized that individual MIPS eligible clinicians or groups who report less than 12 months of data (due to family leave and other issues) will be required to report all performance data available from the applicable performance period (for example, 2018 or a minimum of a continuous 90-day period within the calendar year).

CMS finalizes the following for the 2021 MIPS payment year:

- For the quality and performance categories, the performance period will be the full year (January 1 through December 31) that occurs 2 years prior to the applicable payment year.
- For improvement activities and ACI performance categories, the performance period will be a continuous 90-day period within the calendar year that occurs 2 years prior to the applicable payment year, up to and including the entire calendar year.

CMS is not finalizing any performance periods for the 2022 MIPS payment year and future years.

6. MIPS Category Measures and Reporting

a. Performance Category Measures and Reporting

Submission Mechanisms

In the 2017 QPP final rule, CMS also finalized the data submission mechanisms for MIPS. These final data submission mechanisms are outlined in Table 2 and Table 3 in the final rule and reproduced below.

TABLE 2: Data Submission Mechanisms for MIPS Eligible Clinicians Reporting Individually as TIN/NPI

Performance Category/Submission Combination Accepted	Individual Reporting Data Submission Mechanisms
Quality	Claims QCDR Qualified registry EHR
Cost	Administrative claims (no submission required)
Advancing Care Information (ACI)	Attestation QCDR Qualified registry EHR
Improvement Activities	Attestation QCDR Qualified registry

Performance Category/Submission Combination Accepted	Individual Reporting Data Submission Mechanisms
	EHR

TABLE 3: Data Submission Mechanisms for MIPS Eligible Clinicians Reporting as Groups (TIN)

Performance Category/Submission Combination Accepted	Group Practice Reporting Data Submission Mechanisms
Quality	QCDR Qualified registry EHR CMS Web Interface (groups \geq 25) CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism) and Administrative claims (For all-cause hospital readmission measure - no submission required)
Cost	Administrative claims (no submission required)
Advancing Care Information (ACI)	Attestation QCDR Qualified registry EHR CMS Web Interface (groups \geq 25)
Improvement Activities	Attestation QCDR Qualified registry EHR CMS Web Interface (groups \geq 25)

In the 2017 QPP, CMS also finalized that individual MIPS eligible clinicians and groups may elect to submit information via multiple mechanisms but they could only use one submission mechanism per performance category.

CMS proposed for the 2018 performance period and future year, to allow individual MIPS eligible clinicians and groups to submit measures and activities, as applicable, via as many submission mechanisms as necessary to meet the requirements of the quality, improvement activities or ACI performance categories.

CMS finalizes its proposal with modifications.

- CMS is not finalizing this policy for the 2018 performance period. CMS needs to delay implementation of the policy due to operational reasons, and to allow for additional time to communicate this policy and its interaction with other policies.
 - For the 2018 performance period, CMS will continue the submission policies finalized in the 2017 QPP final rule.
- CMS is finalizing the proposed policy beginning with the 2019 performance period. For purposes of the 2019 performance period (2021 MIPS payment year) and future years, individual MIPS eligible clinicians, groups, and virtual groups may submit data on measures and activities, as applicable, via multiple data submission mechanisms for a

single performance category (specifically, the quality, improvement activities or ACI performance category).

- Individual MIPS eligible clinicians and groups that have fewer than the required number of measures and activities applicable and available under one submission measure may submit data on additional measures and activities through one or more additional submission mechanisms.

CMS finalizes with modifications its proposals for virtual groups. For the 2018 performance period, virtual groups may elect to submit information via multiple submission mechanisms but they must use the same identifier for all practice categories and they may only use one submission mechanism per performance category. Beginning with the 2019 performance period, virtual groups will be able to use multiple submission mechanisms for each performance category.

Specialists who report a specialty measure set are only required to report on the measures within that set, even if it is less than the required 6 measures. Beginning with the 2019 performance period, a specialist would have the option to report additional measures that might be applicable to them which may potentially increase their score, but they are not required to utilize multiple submission methods to meet the 6 measure requirement.

Submission Deadlines

In the 2017 QPP final rule, CMS finalized the submission deadlines for all performance categories. CMS did not propose any changes to the submission deadline.

- The data submission deadline for the qualified registry, QCDR, EHR, and attestation submission mechanisms is March 31 following the close of the performance period. The submission period will begin prior to January 2 following the close of the performance period, if technically feasible. For example, for the 2018 MIPS performance period, the data submission period will occur prior to January 2, 2019, through March 31, 2019, if technically feasible. If it is not technically feasible to allow the submission period to begin prior to January 2 following the close of the performance period, the submission period will occur from January 2 through March 31 following the close of the performance period. In any case, the final deadline will remain March 31, 2019.
- For the Medicare Part B claims submission mechanism, the data must be submitted on claims with dates of services during the performance period and processed no later than 60 days following the close of the performance period.
- For the CMS Web Interface submission mechanism, the data must be submitted during an 8-week period following the close of the performance period that will begin no earlier than January 2 and end no later than March 31. CMS provides an example in which the submission period could span an 8-week timeframe beginning January 16 and end March 13. The specific deadline during this timeframe will be published on the CMS website.

b. Quality Performance Category

(1) Contribution to the Final Score

CMS is finalizing that for the 2020 MIPS payment year (MIPS performance year 2018), the quality performance category will account for 50 percent of the final score.

(2) Quality Data Submission Criteria

Submission Criteria for Quality Measures Excluding Groups Reporting via the CMS Web Interface and CAHPS for MIPS Survey

In the 2017 QPP final rule, CMS finalized the submission criteria listed below. CMS did not propose any changes to these submission criteria or definitions previously established for measures.

- For the applicable period during the performance period, the individual MIPS eligible clinician and group are required to report at least six measures, including at least one outcome measure.
 - If an applicable outcome measure is not available, MIPS eligible clinicians will report one other high priority measure (appropriate use, patient safety, efficiency, patient experience, or care coordination measures).
 - If fewer than six measures apply, MIPS eligible clinicians will then report on each measure that is applicable.
- Alternatively, for the applicable performance period, the MIPS eligible clinician or group will report one specialty-specific measure set, or the measure set defined at the subspecialty level, if applicable.
 - If the measure set contains fewer than six measures, MIPS eligible clinicians will be required to report all available measures within the set.
 - If the measure set contains six or more measures, MIPS eligible clinicians will be required to report at least six measures within the set.
 - Regardless of the number of measures within a measure set, MIPS eligible clinicians will be required to report at least one outcome measure and if no outcome measure is available in the measure set, report another high priority measure (appropriate use, patient safety, efficiency, patient experience, or care coordination measures).

MIPS eligible clinicians and groups will select measures from either the set of all MIPS measures listed or referenced in Table A of the Appendix or one of the set of specialty-specific or subspecialty-specific measures listed in Table B of the Appendix. Previously finalized quality measures may be found in the 2017 QPP final rule (81 FR 77558-77816).

Submission Criteria for Quality Measures for Groups Reporting via the CMS Web Interface.

In the 2017 QPP final rule, CMS finalized the submission criteria listed below. CMS did not propose any changes to these submission criteria or definitions previously established for measures.

- For a registered group of 25 or more MIPS eligible clinicians, report on all the measures included in the CMS Web Interface. The group must report on the first 248

consecutively ranked and assigned Medicare 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.
- A group will be required to report on at least one measure for which there are Medicare patient data.
- Any measure not reported will be considered zero performance for that measure in CMS’ scoring algorithm.

In response to comments, CMS clarifies that the CMS Web Interface criteria applies only to groups of 25 or more eligible clinicians.

Performance Criteria for Quality Measures for Groups Electing to Report CAHPS for MIPS Survey.

In the 2017 QPP final rule, CMS finalized the criteria for the submission of data on the CAHPS for MIPS survey by registered groups via a CMS-approved survey vendor. For the applicable 12-month performance period, a group can voluntarily elect to participate in the CAHPS for MIPS survey. The group must have the survey data reported on its behalf by a CMS-approved survey vendor. In addition, the group will need to use another submission mechanism to complete its remaining quality measure data submission. The survey will count as a measure in the quality performance category and also will fulfill the requirement to report at least one high priority measure in the absence of an applicable outcome measure. The group will be required to submit at least five other measures through one other data submission mechanism. CMS did not propose any changes to these performance criteria.

CMS finalizes its proposal to remove two Summary Survey Measures (SSMs) from the CAHPS for MIPS Survey: “Helping You to Take Medication as Directed” and “Between Visit Communication”. CMS notes that removing this SSM maintains consistency with the Medicare Shared Savings Program, which utilizes the CAHPS for Accountable Care Organizations (ACOs) Survey.

Data Completeness Criteria.

Table 5 in the final rule and abbreviated below provides a summary of the finalized quality data submission criteria for MIPS payment year 2020 and 2021.

Table 5: Summary of Final Quality Data Submission Criteria for MIPS Payment Year 2020 and 2021 via Part B Claims, QCDR, Qualified Registry, EHR, CMS Web Interface, and CAHPS for MIPS Survey*

Clinician Type	Submission Mechanism	Submission Criteria	Data Completeness
Individual MIPS eligible clinicians	Part B Claims	Report at least six measures including one outcome measure. <ul style="list-style-type: none"> • If an outcome measure is not available, report another high priority measure. 	60 percent of individual MIPS eligible clinician’s Medicare Part B patients for the performance period.

Clinician Type	Submission Mechanism	Submission Criteria	Data Completeness
		<ul style="list-style-type: none"> If less than six measures apply, then report on each measure that is applicable. <p>Measures will have to be selected from all MIPS Measures or a set of specialty-specific measures, listed in the applicable final rule.</p>	
Individual MIPS eligible clinicians, groups or virtual groups	QCDR, Qualified Registry, & EHR	<p>Report at least six measures including one outcome measure.</p> <ul style="list-style-type: none"> If an outcome measure is not available, report another high priority measure. If less than six measures apply, then report on each measure that is applicable. <p>Measures will have to be selected from all MIPS Measures or a set of specialty-specific measures, listed in the applicable final rule.</p>	60 percent of individual MIPS eligible clinician's, or group's patients across all payers for the performance period.
Groups	CMS Web Interface	<p>Report on all measures included in the CMS Web Interface <u>and</u> populate data fields for the first 248 consecutively ranked and assigned Medicare beneficiaries in the order in which they appear in the group's sample for each module/measure.</p> <ul style="list-style-type: none"> If the pool of eligible assigned beneficiaries is less than 248, then the group will report on 100 percent of assigned beneficiaries. 	Sampling requirements for the group's Medicare Part B patients
Groups	CAHPS for MIPS Survey	<p>CMS-approved survey vendor would need to be paired with another reporting mechanism to ensure the minimum number of measures is reported.</p> <ul style="list-style-type: none"> The survey would fulfill the requirement for one patient experience measure towards the MIPS quality data submission criteria. The survey will only count for one measure under the quality performance measure 	Sampling requirements for the group's Medicare Part B patients

*The performance period for all the submission criteria for MIPS payment Year 2020 is January 1, 2018 – December 31, 2018 and for payment year 2021 is January 1, 2019 – December 31, 2019.

Additionally, the data submission criteria applicable to groups are also generally applicable to virtual groups. CMS notes that the data completeness and sampling requirements for the CMS Web Interface and CAHPS for MIPS survey differ for virtual groups. For virtual groups, data completeness applies cumulatively across all TINs in a virtual group. For the CMS Web Interface and CAHPS for MIPS survey, the sampling methodology will be conducted for each TIN within the virtual group and then cumulatively aggregated across all the virtual groups. A virtual group would need to meet the beneficiary sampling threshold cumulatively as a group.

(3) Application of Quality Measures to Non-Patient Facing MIPS Eligible Clinicians

In the 2017 QPP final rule, CMS finalized that non-patient facing MIPS eligible clinicians are required to meet the otherwise applicable submission criteria that apply for all MIPS eligible clinicians for the quality performance category. CMS does not propose any changes to this policy.

(4) Global and Population-Based Measures

Section 1848(q)(2)(C)(iii) of the Act allows the Secretary to use global measures, such as global outcomes measures and population-based measures, for the quality performance category.

In the 2017 QPP final rule, CMS finalized the all-cause hospital readmission (ACR) measure from the Value Modifier program (VM) as part of the quality measure domain for the MIPS total performance score. CMS will not apply the ACR measure to solo practices or small groups (groups defined as practices of 15 or fewer clinicians or solo practitioners). CMS will apply the ACR measure to groups of 16 or more who meet the case volume of 200 cases. In addition, a group would be scored on the ACR measure even if it did not submit any quality measures. In 2017, the readmission measure alone would not produce a neutral to positive MIPS payment adjustment. In order to achieve a neutral to positive MIPS payment adjustment, a MIPS eligible clinician or group must submit information on one of the other three performance categories. CMS finalized that the ACR measure is not applicable to MIPS eligible clinicians who do not meet the minimum case requirements.

CMS does not propose any changes for the global and population-based measures.

c. Selection of Quality Measures for Individual MIPS Eligible Clinicians and Groups

(1) Background and Policies for the Call of Measures Available for MIPS Assessment

The appendix to this final rule includes the following detailed tables, which are referenced in this summary but are not reproduced:

- Table A³: New quality measures for reporting in the 2018 performance period and future years,
- Table B⁴: MIPS specialty measure sets for the 2018 performance period and future years,
- Table C.1: MIPS quality measures removed only from specialty sets for the 2018 performance period,
- Table C.2: MIPS quality measures removed from the MIPS for the 2018 performance period,
- Table D: Cross-Cutting measures available for the 2018 performance period and future years,

³ For previously finalized MIPS quality measures, CMS refers readers to Table A in the Appendix of the 2017 QPP final rule (81 FR 77558).

⁴ For previously finalized MIPS specialty measure sets, CMS refers readers to Table E in the Appendix of the 2017 QPP final rule (81 FR 77686). Current specialty measure sets can be found on the QPP website at <https://qpp.cms.gov/measures/quality>.

- Table E: MIPS quality measures with substantive changes for the 2018 performance period and future years.

CMS finalizes its proposal to remove cross-cutting measures from most of the specialty sets. CMS retains the cross cutting measures in Family Practice, Internal Medicine and Pediatrics specialty sets because it believes they are frequently used in these practices. CMS notes that although reporting of a cross-cutting measure is not required, they are included as a reference for clinicians who are looking for additional measures to report outside their specialty.

(2) Topped Out Measures

CMS finalizes its proposal for a 4-year timeline for the identification and proposed removal of topped out measures and to consider removal of the measures from the program through notice-and-comment rulemaking in the 4th year. In the 4th year, if finalized through rulemaking, the measure would be removed and would not be available for reporting during the performance period. CMS notes that although it proposed a 3-year timeline, it is clarifying that the proposed timeline is more accurately described as a 4-year timeline because it may propose to remove the measure through rulemaking in the 4th year.

CMS finalizes that QCDR measures that are consistently identified as topped out, would not be approved for use in year 4 during the QCDR self-nomination review process, and would not go through the rulemaking process. CMS notes that if a measure benchmark were topped out for only one submission mechanism benchmark, it would only remove the measure from that submission mechanism but not remove the measure from other submission mechanisms.

CMS finalizes its proposal to phase in this policy starting with six topped out measures⁵ (discussed further below). CMS also finalizes its proposal to phase in special scoring for measures identified as topped out in the published benchmarks for two consecutive performance periods.

CMS provides the following example illustrating the finalized timeline:

- Year 1: Measures identified as topped out in the benchmarks published for the 2017 MIPS Performance Period. The 2017 benchmarks are posted on the QPP website: <https://qpp.cms.gov/resources/education>.
- Year 2: Measures are identified as topped out in the benchmarks published for the 2018 MIPS performance period.
- Year 3: Measures are identified as topped out in the benchmarks published for the 2019 MIPS performance period. These measures would be considered, through notice-and-comment rulemaking, for removal for the 2020 MIPS performance period.
- Year 4. Topped out measures finalized for removal are no longer available for reporting. For example, the measures in the set of highly topped out measures identified as topped

⁵ The 6 topped out measures are Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin; Melanoma: Overutilization of Imaging Studies in Melanoma; Perioperative Care: Venous Thromboembolism Prophylaxis; Image Confirmation of Successful Excision of Image-Localized Breast Lesion; Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for CT Imaging Description; and Chronic Obstructive Pulmonary Disease: Inhaled Bronchodilator Therapy.

out for the 2017, 2018 and 2019 MIPS performance periods, and if subsequently finalized for removal, will not be available on the list of measures for the 2020 MIPS performance period and future years.

CMS states that for all other measures, the timeline will apply starting with the benchmarks for the 2018 MIPS performance period. Thus, the first year any other topped out measure could be proposed for removal will be in the rulemaking for the 2021 MIPS performance period, based on the benchmarks being topped out in the 2018, 2019, and 2020 MIPS performance periods. If the measure benchmark was not topped out during one of the three MIPS performance periods, then the cycle would stop and start again at year 1 the next time the measure benchmark is topped out.

CMS did not propose to include CMS Web Interface measures in the proposal for removing topped out measures.

d. Cost Performance Category

(1) Weighting in the Final Score

Section 1848(q)(5)(E)(i)(II)(bb) of the Act states the cost performance category will account for no more than 10 percent of the final score for the first MIPS payment year (2019) and not more than 15 percent for the second MIPS payment year (2020). In the 2017 QPP final rule, CMS finalized a weight of 0 percent for the 2019 MIPS payment year and 10 percent for the 2020 MIPS payment year. Starting with the 2021 MIPS payment year, the cost performance category will be weighted at 30 percent.

After consideration of public comments, CMS does not finalize its proposal to weight the cost performance at zero percent for the 2020 MIPS payment year. Instead, CMS adopts its alternative option to maintain the weight of the cost performance category at 10 percent of the final score for the 2020 MIPS payment year as finalized in the 2017 QPP final rule.

(2) Cost Criteria

(a) Measures Proposed for the MIPS Cost Performance Category

For the 2018 MIPS performance period, CMS finalizes its proposal to include the total per capita cost measure and the MSPB measure and not to include any episode-base measures.

Total Per Capita Cost and MSPB Measure.

For the 2018 performance period and future performance periods, CMS finalizes the total per capita cost measure and the MSPB measure as finalized for the 2017 MIPS performance period.

Episode-Based Measures.

For the 2018 MIPS performance period, CMS finalizes its proposal not to include the 10 episode-based measures it adopted in the 2017 performance period and it does not anticipate proposing to include these measures in future performance periods. CMS will continue to work

on the development and outreach for new episode measures. CMS began field testing of new measures in October 2017 and it may propose to include these measures in future rulemaking.

CMS intends to provide feedback on the new measures in the summer of 2018 to those MIPS eligible clinicians for whom it can calculate the episode-based measures. CMS believes that receiving feedback on the new episode-based measures, along with feedback about the total per capita cost and MSPB measures, will allow clinicians to be ready for the 2019 MIPS performance period. Feedback on episode-based measures that were previously developed will be discontinued after 2017.

Attribution.

CMS did not propose any changes to the attribution methods for the MSPB measure. The MSPB is attributed to the TIN that provides the plurality of Medicare Part B claims (as measured by allowable charges) during the index inpatient hospitalization.

The total per capita cost measure uses a two-step attribution methodology that focuses on the delivery of primary care services by both primary care clinicians and specialists. The VM currently defines primary care services as services identified by the following HCPCS codes: 99201 - 99215, 99304 - 99340, 99341 - 99350, G0402 (the welcome to Medicare visit), and G0438 and G0439 (the annual wellness visits). In the 2017 QPP final rule, CMS added the transitional care management codes (99495 and 99496) and the chronic care management code (99490) to the list of primary care codes. CMS finalizes its proposal to add CPT codes 99487 and 99489 (complex chronic care management) to the list of primary care services used to attribute patients under the total per capita cost measure.

(b) Attribution for Individuals and Groups.

In the 2017 QPP final rule, CMS finalized its policy to attribute cost measures for all clinicians at the TIN/NPI level. CMS did not propose any changes to this policy.

(c) Incorporation of Cost Measures with SES or Risk Adjustment.

CMS notes that both the total per capita cost measure and the MSPB measure are risk adjusted to recognize the higher risk associated with demographic factors, such as age, or certain clinical conditions. CMS acknowledges that stakeholders have raised concerns about the need to adjust for other factors such as income level and race.

CMS did not propose any changes to this policy. CMS acknowledges it received comments about risk adjustment that it will consider as part of future rulemaking.

(d) Incorporation of Cost Measures with ICD-10 Impacts.

CMS does not anticipate that measures for the cost performance category will be affected by any ICD-10 issues during the 2018 MIPS performance period. Episode-based measures may be opened (triggered) by and may assign services based on ICD-10 codes, and CMS notes that a change to ICD-10 coding could have a significant effect on an episode-based measure. CMS

will incorporate changes to ICD-10 codes into measure specifications on a regular basis through the measure maintenance process.

(e) Application of Measures to Non-Patient Facing MIPS Eligible Clinicians.

For the 2017 MIPS performance period, CMS finalizes not to have any alternative cost measures for non-patient facing MIPS eligible clinicians or groups. CMS did not propose any changes in this policy. CMS intends to work with non-patient facing MIPS eligible clinicians and specialty societies to propose alternative cost measures in future years.

(f) Facility-Based Measurement as it Relates to the Cost Performance Category.

CMS finalizes its proposed measures related to facility-based measurements. CMS is delaying the implementation of facility-based measurement by 1 year in order to increase clinician understanding and operational readiness.

e. Improvement Activities Category

In the 2017 QPP final rule, CMS defined an improvement activity as an activity that relevant MIPS eligible clinicians, 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.

The appendix to the final rule includes the following detailed tables:

- Table F: New Improvement Activities for the Quality Program Year 2 and Future Years, and
- Table G: Improvement Activities with Changes for the Quality Program Year 2 and Future Years.

Previously finalized improvement activities are listed in Table H of the appendix of the 2017 QPP final rule (81 FR 77817). Except for changes adopted in tables F and Q in this final rule, previously finalized improvement activities continue to apply for the QPP Year 2 and future years.

(1) Contribution to Final Performance Score

In the 2017 QPP final rule, CMS finalizes that the improvement activity performance category will account for 15 percent of the final performance score.

Patient-Centered Medical Home (PCMH).

CMS finalizes its proposal to clarify the term “certified” PCMH to indicate that the term “recognized” is equivalent to the term “certified” when referring to the requirements for the PCMH improvement activities. Specifically, CMS will revise §414.1380(b)(3)(iv) to provide that a MIPS eligible clinician or group in a practice that is certified or recognized as a PCMH or comparable specialty practice receives full credit for performance on the improvement activities performance category. Full credit means that the MIPS eligible clinician or group has met the highest potential category score of 40 points.

Weighting of Improvement Activities.

CMS finalizes new, high weighted and new, medium weighted activities in Table F in the Appendix of this rule. CMS notes that high weighting is used for activities that directly address areas with the greatest impact on beneficiary care, safety, health and well-being.

(2) Improvement Activities Data Submission Criteria

Submission Mechanisms

In the 2017 QPP final rule, CMS finalized that for the first year only, all MIPS eligible clinicians and groups, or third party entities such as health IT vendors, QCDRs and qualified registries that submit for an eligible clinician or group, must designate a yes/no response for activities on the improvement activities inventory. The MIPS eligible clinicians or groups will certify all improvement activities performed, and the third party entity will submit this information on their behalf. CMS finalizes its proposal that the above policy will apply to the first year of MIPS and all future years. CMS notes that in general it is applying finalized group policies to virtual groups.

CMS finalizes that for the 2018 performance period, MIPS eligible clinicians may only use one submission mechanism per performance category. For purposes of the 2021 MIPS payment year (2019 performance period) and future years, individual MIPS eligible clinicians, groups, and virtual groups may submit data on measures and activities, as applicable, via multiple data submission mechanisms for a single performance category (specifically, the quality, improvement activities or ACI performance category).

In the 2017 QPP final rule, CMS clarified that all MIPS eligible clinicians reporting as a group will receive the same score for the improvement activities performance category. If at least one clinician in the group performed the activity for a continuous 90 days in the performance period, the group may report on that activity. CMS notes this policy will also apply to virtual groups. CMS did not propose any changes to this policy.

Submission Criteria.

In the 2017 QPP final rule, CMS finalized that the highest potential score of 100 percent was equivalent to an improvement activity performance score of 40 points and assigned 10 points for a medium-level activity and 20 points for a high-level activity. The minimum reporting period for one improvement activity was finalized as 90 days. CMS established exceptions for small practices, practices located in rural areas; non-patient facing individual MIPS eligible clinicians or groups; and individual MIPS eligible clinicians and groups that participate in a MIPS APM or a PCMH. CMS finalizes its proposals to generally apply finalized group policies to virtual groups. CMS did not propose any changes to the APM scoring standard for MIPS APMs.

Patient-Centered Medical Home (PCMH) or Comparable Specialty Practice. In the 2017 QPP final rule, CMS finalized that practices may receive this designation at a practice level and that TINs may be comprised of both undesignated practices and designated practices and to receive full credit as a PCMH, a TIN must include at least one practice that is a certified PCMH or comparable specialty practice.

CMS finalizes for the 2018 performance year and future years in order to receive full credit as a certified or recognized PCMH or comparable specialty practice, at least 50 percent of the practice sites within the TIN must be recognized or certified as a PCMH or comparable specialty practice. CMS clarifies that a practice site is the physical location where services are delivered.

Comprehensive Primary Care Plus (CPC+) APM design. CMS has determined that the Comprehensive Primary Care Plus (CPC+) APM design satisfies the requirements to be designated as a medical home and is therefore a certified or recognized PCMH for purposes of the improvement activities performance category.

CMS is not finalizing its proposal that MIPS eligible clinicians in practices that have been randomized to the control group in the CPC+ APM would receive full credit as a medical home model and would receive full credit for the improvement activities performance category for each period in which they are on the Practitioner Roster, the official list of eligible clinicians participating in a practice in the CPC+ control group. CMS has not randomized any practice that will begin participation in CPC+ in 2018 into a control group.

Required Period of Time for Performing an Activity

In the 2017 QPP final rule, CMS finalizes that MIPS eligible clinicians or groups must perform improvement activities for at least 90 consecutive days during the performance period for an improvement activity credit. CMS also finalized that where applicable, an improvement activity may have begun prior to the performance period or be adopted in the performance period as long as an activity is being performed for at least 90 days during the performance period. CMS did not propose any changes.

(3) Application of Improvement Activities to Non-Patient Facing Individual MIPS Eligible Clinicians and Groups

In the 2017 QPP final rule, CMS finalized for non-patient facing MIPS eligible clinicians or groups to achieve the highest potential score requires one high-weighted or two medium-weighted improvement activities. For these eligible clinicians and groups, one medium-weighted improvement activity is required to achieve one-half of the highest score. CMS did not propose any changes.

(4) Special Consideration for Small, Rural, or HPSA Practices

In the 2017 QPP final rule, CMS finalized that one high-weighted or two-medium weighted improvement activities are required for individual MIPS eligible clinicians and groups that are small practices or located in rural areas, or geographic HPSAs to achieve full credit. CMS did not propose any changes.

f. Advancing Care Information (ACI) Performance Category

(1) Scoring

Consistent with the requirements in section 1848(q)(5)(E)(i)(IV) of the Act, in the 2017 QPP final rule, CMS finalized that performance in the ACI performance category will comprise 25 percent of a MIPS eligible clinician's final score for MIPS payment year 2019 and each year thereafter. CMS also finalized that the score will be comprised of a score for participation and reporting, referred to as the "base score", a score for performance at varying levels above the base score requirements, referred to as the "performance score", and potential bonus points for reporting on certain measures and activities.

(a) Base Score

In the 2017 QPP final rule, CMS established that MIPS eligible clinicians must report a numerator of at least one for the numerator/denominator measures or a "yes" response for the yes/no measure to earn the base score. The base score is 50 percent of the ACI performance category score. If the requirements for the base score are not met, a MIPS eligible clinician receives a score of zero for the ACI performance category.

For the 2018 performance period, CMS did not propose any changes to the base score methodology.

(b) Performance Score

In the 2017 QPP final rule, CMS finalized that MIPS eligible clinicians can earn 10 percentage points in the performance score for meeting the Immunization Registry Reporting Measure. For the 2018 performance period, CMS proposed to modify this policy because there are areas of the country, where immunization registries are not available.

Beginning with the 2018 performance period, CMS finalizes:

- A MIPS eligible clinician may earn 10 percentage points in the performance score for reporting to any single public health agency or clinical data registry to meet any of the measures associated with the Public Health and Clinical Data Registry Reporting Objective (or any of the measures associated with the Public Health Reporting Objective of the 2018 ACI Transition Objectives and Measures, for clinicians who choose to report on those measures), regardless of whether an immunization registry is available to the clinician. CMS notes that under this policy, a MIPS eligible clinician can earn only 10 percentage points in the performance score, no matter how many agencies or registries they report to.

CMS clarifies that no exclusion is available for the Immunization Registry Reporting Measure for the ACI performance category. The final policy adopted provides flexibility for clinicians to earn performance score points for public health reporting that is not related to immunizations.

(c) Bonus Score

CMS finalizes its proposal that, beginning with the 2018 performance year, a MIPS eligible clinician may only earn the bonus score of 5 percentage points for reporting to at least one

additional public health agency or clinical data registry that is different than the reporting used for the performance score. A MIPS eligible clinician will not receive credit under both the performance score and bonus score for reporting to the same agency or registry.

In response to a comment, CMS clarifies that in order to earn the bonus score, the MIPS eligible clinician must be in active engagement with a different public health agency or clinical data registry than the one reported to earn the 10 percentage points for the performance score. CMS expects to engage in education and outreach efforts about this policy.

(d) Improvement Activities Bonus Score under the ACI Performance Category

Beginning with the 2018 performance period, CMS finalizes with modifications the list of improvement activities that will be eligible for the ACI performance category bonus score if they are completed using CEHRT functionality. The 30 activities eligible for the bonus score include those listed in Table 6 in the final rule. CMS refers readers to Table F and Table G in the appendix of the final rule (Table F: New Improvement Activities for the QPP and Table G: Improvement Activities with Changes for the QPP for information on modifications to the Improvement Activities).

Ten percentage points is the maximum bonus. CMS notes that the weight of the improvement activity for the improvement activities performance category has no effect on the bonus awarded in the ACI performance category.

(2) Performance Periods for the ACI Performance Category

For the 2017 and 2018 performance periods, CMS finalized a minimum of 90 consecutive days of data. CMS encourages MIPS eligible clinicians to report data for the full performance year. CMS maintains this policy as finalized for the 2018 performance period.

For the 2019 performance period (QPP Year 3), CMS finalizes its proposal to accept a minimum of 90 consecutive days of data for the ACI performance category.

(3) Certification Requirements

In this rule, for the 2018 performance period, CMS finalizes its proposal to revise the previously finalized requirements so that MIPS eligible clinicians may use EHR technology certified to either the 2014 or 2015 certification criteria, or a combination of the two. CMS notes that to encourage new participants to adopt certified health IT and to incentivize participants to upgrade their technology to 2015 Edition products, it will offer a one-time bonus of 10 percentage points under the ACI performance category for MIPS eligible clinicians who report the ACI Objectives and Measures for the 2018 performance period using only 2015 edition CEHRT. The bonus is not available to MIPS eligible clinicians who use a combination of the 2014 and 2015 Edition. Table 9 in the final rule lists the 2014 and 2015 Edition certification criteria required to meet the objectives and measures.

(4) Objectives and Measures

(a) ACI Objectives and Measures Specifications

For the 2018 performance period, CMS finalizes with one modification its proposals to change the previously finalized objectives and measures. The difference from the proposed rule is in the description of the Syndromic Surveillance Reporting Measure. For this measure, CMS finalizes that the MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting. This aligns with the measure description finalized for Stage 3. The final rule provides specific details about the additional finalized changes to the following objectives and measures:

- Provide Patient Access Measure;
- View, Download, Transmit (VDT) Measure;
- Health Information Exchange Objective;
- Send a Summary of Care Measure; and
- Syndromic Surveillance Reporting Measure.

CMS also divides the Specialized Registry Reporting Measure into two separate measures, Public Health Registry and Clinical Data Registry Reporting. Beginning with the 2018 performance period, CMS finalizes its proposal to allow MIPS eligible clinicians and groups to count active engagement in electronic public health reporting with specialized registries for purposes of reporting the Public Health Registry Reporting Measure or the Clinical Data Registry Reporting Measure. A MIPS eligible clinician may count a specialized registry if the clinician achieved the phase of active engagement as described under “active engagement option 3: production” in the EHR Incentive Program final rule (80 FR 62862-62865), meaning the clinician has completed testing and validation of the electronic submission and is electronically submitting production data to the public health agency or clinical data registry.

(b) 2017 and 2018 ACI Transition Objectives and Measures

In the 2017 QPP final rule, CMS finalized the 2017 ACI Transition Objectives and Measures for MIPS eligible clinicians using EHR technology certified to the 2014 Edition. These objectives and measures had been adapted from the Modified Stage 2 objectives and measures finalized in the 2015 EHR Incentive Programs Final Rule (80 FR 62793 – 62825). Because in the 2018 QPP proposed rule CMS proposed to continue to allow the use of EHR technology certified to the 2014 Edition in the 2018 performance period, it also proposed to allow MIPS eligible clinicians to report the 2017 ACI Transition Objectives and Measures in 2018.

For the 2018 performance period, CMS finalizes its proposal to maintain these ACI Objectives and Measures. Tables 7 and 8 in the final rule and reproduced below list the 2018 ACI Objectives and Measures.

CMS also finalizes its proposed modifications for the measures listed below. The reader is referred to the discussion in the final rule for more specific details about the proposed modifications for the following:

- Patient Electronic Access Objective;
- Patient-Specific Education Objective;
- Health Information Exchange Objective;
- Health Information Exchange Measure;
- Medication Reconciliation Objective; and

- Medication Reconciliation Measure.

Table 7: 2018 Performance Period Advancing Care Information Performance Category Scoring Methodology for 2018 Advancing Care Information Objectives and Measures

2018 ACI Objective	2018 ACI Measure	Required/Not Required for Base Score (50%)	Performance Scoring (up to 90%)	Reporting Requirement
Protect Patient Health Information	Security Risk Analysis	Required	0	Yes/No Statement
Electronic Prescribing	e-Prescribing**	Required	0	Numerator/Denominator
Patient Electronic Access	Provide Patient Access	Required	Up to 10%	Numerator/Denominator
	Patient-Specific Education	Not Required	Up to 10%	Numerator/Denominator
Coordination of Care Through Patient Engagement	View, Download, or Transmit (VDT)	Not Required	Up to 10%	Numerator/Denominator
	Secure Messaging	Not Required	Up to 10%	Numerator/Denominator
	Patient-Generated Health Data	Not Required	Up to 10%	Numerator/Denominator
Health Information Exchange	Send a Summary of Care**	Required	Up to 10%	Numerator/Denominator
	Request/Accept Summary of Care**	Required	Up to 10%	Numerator/Denominator
	Clinical Information Reconciliation	Not Required	Up to 10%	Numerator/Denominator
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting	Not Required	0 or 10%	Yes/No Statement
	Syndromic Surveillance Reporting	Not Required	0 or 10%*	Yes/No Statement
	Electronic Case Reporting	Not Required	0 or 10%*	Yes/No Statement
	Public Health Registry Reporting	Not Required	0 or 10%*	Yes/No Statement
	Clinical Data Registry Reporting	Not Required	0 or 10%*	Yes/No Statement
Bonus (up to 25%)				
Report to one or more additional public health and clinical data registries beyond the one identified for the performance score			5% bonus	Yes/No Statement
Report improvement activities using CEHRT			10% bonus	Yes/No Statement
Report using only 2015 Edition CEHRT			10% bonus	Based upon measures submitted

* A MIPS eligible clinician may earn 10% for each public health agency or clinical data registry to which the clinician reports, up to a maximum of 10% under the performance score.

** Exclusions are available for these measures.

Table 8: 2018 Performance Period Advancing Care Information Performance Category Scoring Methodology for 2018 Advancing Care Information Transition Objectives and Measures

2018 ACI Transition Objective	2018 ACI Transition Measure	Required/Not Required for Base Score (50%)	Performance Scoring (up to 90%)	Reporting Requirement
Protect Patient Health Information	Security Risk Analysis	Required	0	Yes/No Statement
Electronic Prescribing	e-Prescribing**	Required	0	Numerator/Denominator
Patient Electronic Access	Provide Patient Access	Required	Up to 20%	Numerator/Denominator
	View, Download, or Transmit (VDT)	Not Required	Up to 10%	Numerator/Denominator
Patient-Specific Education	Patient-Specific Education	Not Required	Up to 10%	Numerator/Denominator
Secure Messaging	Secure Messaging	Not Required	Up to 10%	Numerator/Denominator
Health Information Exchange	Health Information Exchange**	Required	Up to 20%	Numerator/Denominator
Medication Reconciliation	Medication Reconciliation	Not Required	Up to 10%	Numerator/Denominator
Public Health Reporting	Immunization Registry Reporting	Not Required	0 or 10%*	Yes/No Statement
	Syndromic Surveillance Reporting	Not Required	0 or 10%*	Yes/No Statement
	Specialized Registry Reporting	Not Required	0 or 10%*	Yes/No Statement
Bonus (up to 15%)				
Report to one or more additional public health and clinical data registries beyond the one identified for the performance score			5% bonus	Yes/No Statement
Report improvement activities using CEHRT			10% bonus	Yes/No Statement

* A MIPS eligible clinician may earn 10% for each public health agency or clinical data registry to which the clinician reports, up to a maximum of 10% under the performance score.

** Exclusions are available for these measures.

(c) Exclusions

CMS finalizes its proposal to establish an exclusion for the e-Prescribing Measure. Specifically, MIPS eligible clinicians who wish to claim this exclusion may select “yes” to the exclusion and submit a null value for the measure. This change will allow the clinician to fulfill the requirement to report this measure as part of the base score.

For the Health Information Exchange Objective, CMS finalizes additional exclusions for MIPS eligible clinicians who are unable to meet the measures required for the base score because they do not regularly refer or transition patients. For the Send a Summary of Care Measure, CMS finalizes its proposal to exclude any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period. For the Request/Accept Summary of Care Measure, CMS finalizes its proposal to exclude any MIPS

eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period.

CMS finalizes that these exclusions will apply beginning with the 2017 performance period.

(5) Additional Considerations

(a) 21st Century Cures Act

In this final rule, CMS adopts the proposals described below to implement the Cures Act provisions into the assessment of MIPS eligible clinicians under section 1848(q) of the Act.

i. MIPS Eligible Clinicians Facing a Significant Hardship. In the 2017 QPP final rule, CMS finalized that MIPS eligible clinicians facing a significant hardship or do not have face-to-face interactions with patients would be assigned a zero percent weighting to the ACI performance category in the final score. Significant hardships included insufficient internet connectivity, extreme and uncontrollable circumstances, and lack of control over the availability of CEHRT. MIPS eligible clinicians have to annually submit an application that includes information about why the EHR technology is not available and the related duration the technology will be unavailable. For a MIPS eligible clinician who is classified as a non-patient facing MIPS eligible clinician (based on the number of patient-facing encounters billed during a performance period), CMS does not require an application to be submitted by the eligible clinician. CMS did not impose a limitation on the number of MIPS payment years that an exception could be granted.

CMS will use the same categories of significant hardship and the application process established in the 2017 QPP final rule (81 FR 77240-77243). CMS will automatically reweight the ACI performance category to zero percent in the MIPS final score for the MIPS payment year for a MIPS eligible clinician who is classified as a non-patient facing clinician without requiring an application. CMS will not apply any time limitation for this exception.

CMS notes that if a MIPS eligible clinician with a significant hardship exception believes there are sufficient ACI measures applicable to them, they have the option to report the ACI measures for the performance period for which they have an exception. If an exempted clinician reports on the ACI measures, they will be scored and the category will be weighted in the same manner as for all other MIPS eligible clinicians.

ii. Significant Hardship Exception for MIPS Eligible Clinicians in Small Practices. In the 2017 QPP final rule, CMS finalized that MIPS eligible clinicians and groups in small practices or located in rural areas or geographic HPSAs, must submit one high-weighted or two medium-weighted improvement activities to achieve full credit under the ACI category.

In this rule, CMS finalizes its proposal for a significant hardship for the ACI category for MIPS eligible clinicians in small practices defined under §414.1305 (15 or fewer clinicians and solo practitioners). For these clinicians, beginning with the 2018 performance period, the ACI performance category will be reweighted to zero percent of the MIPS final score. To qualify for

this exception, MIPS eligible clinicians will submit an application to CMS by December 31 of the performance period or a later date specified by CMS. MIPS eligible clinicians will need to demonstrate that there are overwhelming barriers that prevent them from complying with the ACI requirements. CMS will not apply any time limitation for this exception.

iii. Hospital-Based MIPS Eligible Clinicians. In the 2017 QPP final rule, CMS defined a hospital-based MIPS eligible clinician as a MIPS eligible clinician who furnishes 75 percent or more of their covered professional services in the sites of care identified by the Place of Service (POS) codes used in the HIPAA standard transaction as an inpatient hospital (POS 21), on-campus outpatient hospital (POS 22) or emergency room (POS 23) settings, based on claims for a period prior to the performance year as specified by CMS. In making this determination, CMS intends to use claims with dates of services between September 1 of the year that is 2 years preceding the performance period through August 31 of the year preceding the performance period. CMS notes that if it is not operationally feasible to use claims from this time period, it will use a 12-month period as close as practicable to this time period.

While CMS did not propose substantive changes in the policy, it finalizes its proposal, using the authority in section 1838(o)(2)(D) of the Act, to automatically reweight the ACI performance category to zero percent in the MIPS final score for the MIPS payment year. CMS will not apply any time limitation for this exception.

CMS notes, however, that if a MIPS eligible clinician believes there are sufficient ACI measures applicable to them, they have the option to report the ACI measures for the performance period for which they are determined hospital-based. If an exempted hospital-based clinician reports on the ACI measures, they will be scored and the category will be weighted in the same manner for as all other MIPS eligible clinicians.

iv. Ambulatory Surgical Center (ASC) – Based MIPS Eligible Clinicians. Section 16003 of the 21st Century Cures Act amended section 1848(a)(7)(D) of the Act to provide that no payment adjustment may be made under section 1848(a)(7)(A) of the Act for 2017 and 2018 for EPs who furnish substantially all of their covered professional services in an ASC. The determination of whether an EP is ASC-based may be made on the site of service defined by the Secretary or by attestation; the determination is made without regard to any employment or billing arrangement between the EP and any other supplier or provider of services. The ASC-based exemption shall no longer apply as of the first year that begins more than 3 years after the date on which the Secretary determines, through rulemaking, that CEHRT applicable to the ASC setting is available.

Consistent with the policy for hospital-based MIPS eligible clinicians, CMS finalizes its proposal to define an ASC-based MIPS eligible clinician as a MIPS eligible clinician who furnishes 75 percent or more of their covered professional services in the sites of care identified by the POS code used for an ASC (POS code 240), based on claims for a period prior to the performance year as specified by CMS. CMS notes that the ASC-based determination will be made independent of the hospital-based determination. CMS finalizes that ASC-based policies will apply beginning with the 2017 performance period.

CMS finalizes its proposal to use claims with dates of services between September 1 of the year that is 2 years preceding the performance period through August 31 of the year preceding the performance period to identify ASC-based MIPS eligible clinicians. CMS notes that if it is not operationally feasible to use claims from this time period, it will use a 12-month period as close as practicable to this time period. This timeline allows notification of ASC-based status prior to the start of the performance period and aligns the determination with the hospital-based MIPS eligibility determination period. CMS expects it will provide notification through the QPP website.

CMS finalizes its proposal to automatically reweight the ACI performance category to zero percent in the MIPS final score for the MIPS payment year for ASC-based MIPS eligible clinicians. CMS notes, however, that if a MIPS eligible clinician believes there are sufficient ACI measures applicable to them, they have the option to report the ACI measures for the performance period for which they are determined ASC based. If an exempted ASC-based clinician reports on the ACI measures, they will be scored and the category will be weighted in the same manner for as all other MIPS eligible clinicians.

v. Exceptions for MIPS Eligible Clinicians Using Decertified EHR Technology.

CMS finalizes its proposal that a MIPS eligible clinician may demonstrate through an application process that reporting on the measures specified for the ACI performance period is not possible because the CEHRT used by the MIPS eligible clinician has been decertified under ONC's Health IT Certification Program. If an exception is granted, CMS will assign the clinician a zero percent weight to the ACI performance category in the MIPS final score. The exception will be subject to annual renewal and will not be granted for more than 5 years. The exception will be available beginning with the 2018 performance period.

CMS finalizes its proposal that a MIPS eligible clinician may qualify for this exception if their CEHRT was decertified either during the performance period for the MIPS payment year or during the year preceding the performance period for the MIPS payment year. CMS believes this time frame is appropriate because switching to an alternative CEHRT may take up to 2 years. CMS also finalizes that the application and supporting documentation must demonstrate that the MIPS eligible clinician made a good faith effort to adopt and implement another CEHRT in advance of the performance period. The application for this exception will be submitted in a form and manner specified by CMS by December 31st of the performance period, or a later date specified by CMS.

(b) Hospital-Based MIPS Eligible Clinicians

In the 2017 QPP final rule, CMS defined a hospital-based MIPS eligible clinician as a MIPS eligible clinician who furnishes 75 percent or more of their covered professional services in the sites of care identified by the POS codes used in the HIPAA standard transaction as an inpatient hospital (POS 21), on-campus outpatient hospital (POS 22) or emergency room (POS 23) settings, based on claims for a period prior to the performance year as specified by CMS.

CMS finalizes its proposal to modify this policy to include covered professional services furnished by MIPS eligible clinicians in an off-campus outpatient hospital (POS 19) in the

definition of hospital-based MIPS eligible clinician. POS 19 was developed to capture physicians that are paid for a portion of their services in an “off campus-outpatient hospital” vs. an on campus-outpatient hospital (POS 22). CMS believes that these MIPS eligible clinicians will not typically have control of the development and maintenance of their ER systems, just like those who bill using POS 22.

(c) Scoring for the MIPS Eligible Clinicians in Group Practices

In the 2017 QPP final rule, CMS finalized that for group reporting of the ACI performance category the group data would be aggregated for all MIPS eligible clinicians within the group practice. CMS notes this includes MIPS eligible clinicians who may qualify for a zero percent weighting of the ACI performance category due to the circumstances described above, such as significant hardship exception, hospital-based or ASC-based status, or certain types of non-physician practitioners. If these MIPS eligible clinicians report are part of a group or virtual group, they will be scored on the ACI performance category like all other MIPS eligible clinicians and the performance category will be given the weight of the group practice’s ACI performance category score. CMS did not propose any changes to this policy.

In response to comments, CMS reiterates that 100 percent of the MIPS eligible clinicians in the group must qualify for a zero percent weighting in order for the ACI performance category to be reweighted in the final score.

(d) Timeline for Submission of Reweighting Applications

In the 2017 QPP final rule, CMS established the timeline for submission of applications to reweight the ACI performance category. An application would need to be submitted annually to be considered for reweighting each year.

CMS states that the QPP Exception Application will be used to apply for the following exceptions: insufficient internet connectivity; extreme and uncontrollable circumstances; lack of control over the availability of CEHRT; decertification of CEHRT; and small practices.

CMS finalizes its proposal to change the submission deadline for the 2017 performance period to December 31, 2017, or a later date specified by CMS. This will allow clinicians to know whether their application is approved prior to the data submission deadline for the 2017 performance period, which is March 31, 2018. CMS notes that the submission of QPP Hardship Exceptions applications began in August 2017 and will close at the end of 2017.

CMS also finalizes its proposal that the submission deadline for the 2018 performance period will be December 31, 2018 or a later date as specified by CMS.

g. APM Scoring Standard for MIPS Eligible Clinicians in MIPS APMs

(1) Assessment Dates for Inclusion of MIPS Eligible Clinician Inclusion in APM Entity Groups Under the APM Scoring Standard

CMS currently identifies MIPS eligible clinicians on each MIPS APM Entity's Participation List and their associated groups on three assessment dates: March 31, June 30, and August 31. CMS finalizes its proposal to add December 31 as a fourth assessment date. This last date will only be available to "full TIN" APMs, defined as APMs where participation is defined at the TIN level, and all eligible clinicians who have assigned their billing rights to a participating TIN (e.g., Medicare Shared Savings Program). The December 31 date will only be used to identify MIPS eligible clinicians on the APM Entity's Participation List for a MIPS APM that is a full TIN APM in order to add them to the APM Entity group that is scored under the APM scoring standard.

CMS will continue to use only the three current assessment dates to identify the MIPS eligible clinicians participating in MIPS APMs that are not full TIN APMs.

(2) MIPS APM Performance Category Score Calculations

(a) Cost Category Waivers

CMS finalizes its proposal to continue to use its authority to waive the requirements of the statute and to reweight the cost performance category to zero for MIPS APMs for the 2020 payment year and subsequent payment years. CMS also finalizes its proposal to use its authority to waive the requirements of the statute to take improvement into account for performance scores in the cost performance category beginning with the 2018 MIPS performance period.

(b) Quality Category Scoring

Web Interface Reporters

In the 2017 QPP final rule, CMS adopted that under the APM scoring standard, participants in the Medicare Shared Savings Program (MSSP) and Next Generation ACOs would have the MIPS APM quality performance category score based exclusively on quality measures submitted via the CMS Web Interface. The measures required for 2017 were also MIPS measures. CMS refers to these MIPS APMs as "Web Interface reporters".

CMS finalizes the following proposals for the 2018 performance period:

- Score the CAHPS for ACOs survey in addition to the CMS Web Interface measures that are used to calculate the MIPS APM quality performance category score for Web Interface reporters.
 - The CAHPS for ACOs survey is identical to the CAHPS for MIPS survey except it has one less survey question -- Between Visit Communication. Table 10 in the final rule provides additional information about the CAHPS for ACO survey.

- MIPS eligible clinicians in Web Interface reporters may receive bonus points under the APM scoring standard for submitting the CAHPS for ACO survey.
 - MIPS eligible clinicians in MIPS APS, like all MIPS eligible clinicians, are also subject to the 10 percent cap on bonus points for reporting priority measures.
 - Web Interface reporters will only receive bonus points if they submit a high priority measure with a performance rate that is greater than zero and the data for the measure meets the case minimum requirements.
- CMS will calculate the quality improvement score for MIPS eligible clinicians submitting quality measures via the Web Interface, including those participating in MIPS APMs, if data sufficient to measure quality improvement is available.
- CMS will calculate the total quality percent score for MIPS eligible clinicians submitting quality measures via the Web Interface using the methodology for scoring MIPS eligible clinicians reporting on quality through the CMS Web Interface.

In response to a comment, CMS clarifies that APM Entity groups, are treated like other MIPS groups, and will receive quality improvement scores for any year following a year in which one or more members of the APM Entity group was subject to MIPS and received a quality score. If the APM Entity group did not exist or receive a quality score but some of its participant TIN/NPIs received quality scores in the previous performance period, the mean of those scores will be applied to the APM Entity group for the purpose of calculating quality improvement points. If the APM Entity did not exist or receive a quality score and none of its participating MIPS eligible clinicians received quality scores in the previous performance period, no quality improvement points will be awarded.

Other MIPS APM Quality Scoring.

CMS finalizes its proposal to define the term “Other MIPS APM” as a MIPS APM that does not require reporting through the Web Interface. For the 2018 MIPS performance year, Other MIPS APMs includes the Comprehensive ESRD Care Model (CEC), the Comprehensive Primary Care Plus Model (CPC+), and the Oncology Care Model (OCM).

CMS finalizes the proposals that beginning with the 2018 MIPS performance period, it will use quality measure performance data to generate a MIPS quality performance category score for Other MIPS APMs.

CMS also finalizes its proposal for calculating the MIPS quality performance category score for Other MIPS APMs using MIPS APM-specific quality measures. The measure sets on the list will represent all possible measures which may contribute to an APM Entity’s MIPS score for the MIPS quality performance category and may include measures that are the same or similar to those used by MIPS. CMS may not score a measure if a measure’s data is inappropriate or unavailable for scoring. Tables 14 – 16 in the final rule contain the finalized MIPS APM measure lists for the Oncology Care Model, CEC, and CPC+s (Other MIPS APMs).

In response to comments, CMS clarifies that it will not be scoring performance for any measure not included on the MIPS APM quality measure list included in each year’s proposed rule.

Measure Requirements. CMS finalizes the proposed policy to score only:

- Measures that are tied to payment as described under the terms of the APM;
- Measures that are available for scoring near the close of the MIPS submission period;
- Measures that have a minimum of 20 cases available for reporting; and
- Measures that have an available benchmark at 414.1370(g)(1)(ii)(A)(1) through (4).

CMS clarifies that pay-for-reporting measures will not be scored because they do not have an available benchmark and it does not believe it is necessary to explicitly exclude these measures.

CMS intends to only use the MIPS APM quality measure data that are submitted by the close of the MIPS submission period and are available for scoring in time for inclusion to calculate the quality performance category score. In response to a comment, CMS reiterates that entities that do not reach the 20 case minimum for a particular measure will not be penalized for not reporting the measure. In this situation, the measure will receive a null score and will be removed from the numerator and denominator when calculating the total quality score.

For the APM scoring standard, CMS finalizes the following proposals for the benchmark score:

- The benchmark will be the benchmark used in the MIPS APM for calculation of the performance based payments, when such a benchmark is available.
- If the MIPS APM does not produce a benchmark score for a reportable measure on the MIPS APM measure list, CMS will use the benchmark score for the measure that is used for the MIPS quality performance category, provided the measure specifications for the measure are the same under both the MIPS final list and the APM measure list.
- If neither the APM nor MIPS have a benchmark available for a reported measure, the APM Entity that reported the measure will receive a null score for that measure and the measure will be removed from both the numerator and denominator of the quality performance category percentage.

Calculating the Quality Category Performance Category Percent Score.

CMS finalizes its proposal that under the APM Scoring Standard the minimum number of measures to be reported will equal the minimum number of quality measures required by the MIPS APM and are collected and available in time to be included in the calculation for the APM Entity Score under the APM scoring standard. The data must be submitted before the APM's submission deadline.

CMS also finalizes that points will be given for those measures submitted timely and that all remaining required minimum measures would each be scored at zero. A quality category percentage score of zero will be assigned if the MIPS APM failed to submit any measures on time. Measures failing case minimums or without available benchmarks will be removed from scoring.

CMS finalizes it will assign bonus points for reporting high priority measures or measures with end-to-end CEHRT reporting, consistent with the general MIPS scoring (81 FR 77297-77299).

Quality Measures Benchmarks. For measure scoring under the APM Scoring Standard, CMS finalizes its proposal to assign point scores based on benchmark percentile distributions that are separated by deciles. For each benchmark, CMS will calculate the decile breaks for measure performance and assign points based on the benchmark decile range into which the APM Entity's measure performance falls.

Point assignment will be graduated, spread over a continuum, and taken out to one decimal place. For each measure that can be reliably scored, CMS will assign 1-10 achievement points, up to the number of measures required under the terms of the MIPS APM. CMS finalizes it will identify if any of the available measures within the MIPS APM measure sets are bonus-eligible (e.g., multiple high priority measure reporting). Maximum bonus points awarded to an entity group may not exceed 10 percent of their total available bonus points.

Achievement Points. CMS finalizes its proposal that each APM Entity that reports on quality measures will receive between 1 and 10 achievement points for each measure reported that can be reliably scored against a benchmark, up to the number of measures that are required to be reported by the APM (82 FR 30086 through 30087).

To determine the APM Entity's quality performance quality percentage, achievement points will be added to any applicable bonus points and then divided by the total number of available achievement points, with a cap of 100 percent. (More information about the MIPS quality performance category percentage score calculation is provided below in section II.A.7.a of this summary.) For each measure set, the total available achievement points will be the number of required, reliable, available measures multiplied by ten. CMS provides an example in which an APM Entity reports on four out of four required measures. If the APM receives an achievement score of five on each measure and no bonus points, the APM Entity's quality performance category percentage will be 50 points or [(5 points x 4 measures) + 0 bonus points]/ (4 measures x 10 maximum available points).

Quality Improvement Scoring

For the APM scoring standard, CMS finalizes the quality percentage points will be awarded based on the following formula for the quality improvement score:

$$\text{Quality Improvement Score} = (\text{absolute improvement/ previous year performance category score prior to bonus points}) \times 10$$

CMS notes it inadvertently described the formula in the proposed rule but provided a cross-reference to the discussion and the correct formula under the general MIPS scoring standard (82 FR 300096). In the proposed rule the improvement calculation was divided by 10 instead of multiplied by 10.

Calculating Total Quality Performance Category Score

CMS finalizes the proposed quality performance category score:

$$\text{Quality Performance Category} = [(\text{Achievement Points} + \text{Bonus Points})]/\text{Total Achievement Points} + \text{Quality Improvement Score}$$

The APM's total quality performance score cannot exceed 100 percent.

(c) Improvement Activities Performance Category

CMS did not propose any changes to the existing policy.

As described in the 2017 QPP final rule, for all MIPS APMS, CMS will assign the same improvement score to each APM Entity based on the activities involved in participation in a MIPS APM. APM Entities will receive a minimum of one half of the total possible points in this category. If the assigned score does not represent the maximum improvement activities score, the APM Entity will have the opportunity to report additional improvement activities to add points to the APM Entity level score (discussed in section II.A.7.a.).

(d) Advancing Care Information (ACI) Category

In the 2017 QPP final rule, CMS adopted it would attribute one score to each MIPS eligible clinician in an APM entity by looking for both individual and group TIN level data submitted for the clinician, and use the highest available score. CMS then creates an APM Entity's score based on the average of the highest scores available for MIPS eligible clinicians in the APM Entity group. If an individual or TIN did not report on the ACI category, they contribute a zero to the APM Entity's aggregate score.

In the 2017 QPP final rule, CMS finalized it will assign a weight of zero percent to the ACI performance category in the final score for MIPS eligible clinicians who meet specific criteria: hospital-based MIPS eligible clinicians, MIPS eligible clinicians facing a significant hardship, and certain types of non-physician practitioners (NPs, PAs, CRNAs, and CNSs) who are MIPS eligible clinicians. In this final rule, CMS extends this policy to include ASC-based MIPS eligible clinicians and MIPS eligible clinicians who are using decertified EHR technology

CMS finalizes the following proposals:

- If a TIN includes a MIPS eligible clinician who qualifies for a zero percent weighting of the ACI performance category and also includes one or more MIPS eligible clinicians who do not qualify for a zero percent weight, the TIN is required to report the group's ACI data. All MIPS eligible clinicians in the TIN will count towards the TIN's weight for calculating an APM Entity score for the ACI performance category.
- If all the MIPS eligible clinicians in a TIN qualify for the zero percent weighting, the TIN will not be required to report ACI data. The ACI category weight is set to zero percent for the TIN, and the ACI weight is redistributed to the quality category.
- If ACI data are reported by one or more TINs in an APM Entity, an ACI performance category score will be calculated for all the MIPS eligible clinicians in the APM Entity group. If all MIPS eligible clinicians in all the TINs in an APM Entity qualify for a zero percent weighting, the ACI category weight is set to zero percent for the TIN, and the ACI weight is redistributed to the quality category.

(3) Total APM Entity Score Calculation

(a) Performance Category Weighting

Beginning with the 2018 performance, CMS finalizes its proposal to use waiver authority to set performance category weights for the Other Payer APMs to align with the Web Interface reporters performance category weights of the final score: Cost to 0 percent, Quality to 50 percent, Improvement Activities to 20 percent, and ACI to 30 percent.

Table 12 in the final rule, reproduced below provides information about the APM performance category weights.

Table 12: APM Scoring Standard Performance Category Weights – Beginning with the 2018 Performance Period

MIPS Performance Category	APM Entity Submission Requirement	Performance Category Score	Performance Category Weight
Quality	APM Entity will be required to submit quality measures to CMS Web as required by the MIPS APM. Measures available at the close of the MIPS submission period will be used to calculate the quality performance category score. If the APM Entity does not submit any APM required measures by the submission deadline, the APM Entity will be assigned a zero.	CMS will assign the same quality performance score to each TIN/NPI in an APM Entity group based on the APM's total quality score, derived from available APM measures.	50%
Cost	The APM Entity group will not be assessed on cost.	Not applicable	0%
Improvement Activities	MIPS eligible clinicians are not required to report improvement activities. If the CMS-assigned improvement activities score is below the maximum improvement activities score, APM Entities will have the opportunity to submit additional improvement activities to raise the APM Entity improvement activity score.	CMS will assign the same improvement activities score to each APM Entity based on the activities involved in participation in the MIPS APM. APM Entities will receive a minimum score of one half of the total possible scores. If the assigned score does not represent the maximum improvement activities score, the APM Entity will have the opportunity to report additional improvement activities to add points to the APM Entity score.	20%
Advancing Care	Each MIPS eligible clinician in the APM Entity	CMS will attribute the same score to each MIPS eligible clinician in	30%

MIPS Performance Category	APM Entity Submission Requirement	Performance Category Score	Performance Category Weight
Information (ACI)	is required to report ACI to MIPS through either the group TIN or individual reporting.	the APM Entity group. This score will be the highest score attributable to the TIN/NPI contribution of each MIPS eligible clinician, which may be derived from either group or individual reporting. The scores attributed to each MIPS eligible clinician will be averaged for a single APM Entity score.	

Table 13 in the final rule, provides information about the APM scoring standard for overall reweighting when either the quality or ACI category weights are reset to zero percent for a MIPS APM Entity. For reweighting CMS finalizes:

- If the quality performance category is reweighted to zero, CMS will reweight the improvement activities and ACI performance categories to 25 and 75 percent, respectively.
- If the ACI performance category is reweighted to zero, the quality performance category will be increased to 80 percent and the improvement activities performance category will remain at 20 percent.

(b) Scoring for Bonuses

CMS finalizes that MIPS eligible clinicians can earn up to 5 bonus points for the treatment of complex patients, based on a combination of the Hierarchical Condition Categories (HCCs) and the number of dually eligible patients treated. The description of the complex patient bonus and its applications to APM Entities is discussed in a subsequent section.

CMS finalizes that a small practice bonus of 5 points will be added to any MIPS eligible clinician or small group who’s in a small practice (defined as 15 or fewer eligible clinicians), as long as the MIPS eligible clinician or group submits data on at least 1 performance category in an applicable performance period. The description of the small practice bonus and its applications to APM Entities is discussed below in a subsequent section.

(4) MIPS APM Performance Feedback

CMS finalizes the following proposals:

- MIPS eligible clinicians whose MIPS payment adjustment is based on their score under the APM scoring standard will receive performance feedback for the quality, ACI, and information activities performance categories to the extent data are available for the MIPS performance period.
- Feedback for the cost performance category for MIPS eligible clinicians participating in MIPS APMs authorized under sections 115A and 1899 of the Act, respectively, will be

waived in all years, regardless of the availability of cost performance data for MIPS eligible clinicians participating in these MIPS APMs.

7. MIPS Final Score Methodology (§414.1380)

For the 2020 MIPS payment year, CMS built on the scoring methodology it finalized for the transition year. CMS proposed refinements to the performance standards, the methodology for determining a score for each of the four performance categories (the “performance category score,” and the methodology for determining a final score based on the performance category scores. In brief, CMS proposed the following policies (which are discussed in detail in the below sections):

- Continuation of many transition year scoring policies in the quality performance category, with an adjustment to the number of achievement points available for measures that fail to meet the data completeness criteria, to encourage MIPS eligible clinician to meet data completeness while providing an exception for small practices;
- An improvement scoring methodology that rewards MIPS eligible clinicians who improve their performance in the quality and cost performance categories;
- A new scoring option for the quality and cost performance categories that allows facility-based MIPS eligible clinicians to be scored based on their facility’s performance;
- Special considerations for MIPS eligible clinicians in small practices or those who care for complex patients; and
- Policies that allow multiple pathways for MIPS eligible clinicians to receive a neutral to positive MIPS payment adjustment.

CMS stated its belief that these policies will help clinicians smoothly transition from the transition year to the 2020 MIPS payment year.

a. Converting Measures and Activities into Performance Category Scores

(1) Policies that Apply Across Multiple Performance Categories

This section discusses the policies that apply across multiple performance categories.

Performance Standards

CMS finalized standards for the four performance categories in the 2017 QPP final rule (81 *FR* 77271-77272) and refers readers to this final rule for further description of the performance standards against which measures and activities in the four performance categories are scored.

Policies Related to Scoring Improvement

CMS finalizes its proposal to add that improvement scoring is available for performance in the quality performance category and for the cost performance category beginning with the 2020 MIPS payment year. CMS did not propose to score improvement in the improvement activities

performance category or the advancing care information performance category at this time, though it may consider this issue in future rulemaking.

Scoring Flexibility for ICD-10 Measure Specification Changes During the Performance Period

CMS finalizes its proposal to assess performance for significantly impacted measures based on the first 9 months of the performance period, rather than the full 12 months. Those measures not significantly impacted by the changes to ICD-10 codes will continue to be assessed on the full 12-month performance period (January 1 through December 31).

CMS finalizes its proposed annual review process to analyze the measures that have a code impact and determine those measures significantly impacted by ICD-10 coding changes during the performance period. CMS states that depending on the data available, its determination as to whether a measure is “significantly” impacted will include one or more of these factors: a more than 10 percent change in codes in the measure numerator, denominator, exclusions, and exceptions; clinical guideline changes or new products or procedures reflected in ICD-10 code changes; and feedback on a measure received from measure developers and stewards.

CMS finalizes its proposal to publish on the CMS website the measures that are significantly impacted by ICD-10 coding changes and would require the 9-month assessment. In addition, CMS will publish this information by October 1st of the performance period if technically feasible, but by no later than the beginning of the data submission period, which is January 1, 2019 for the 2018 performance period.

(2) Scoring the Quality Performance Category for Data Submission via Multiple Mechanisms

CMS finalizes its proposal to present the quality performance category score as a percentage rather than as a fraction from zero to 1 and refer to it as “quality performance category percent score” instead of a “quality performance category score.” Thus, the formula for the quality performance category percent score that CMS will use in this section is as follows:

$$\frac{(\text{total measure achievement points} + \text{total measure bonus points})}{\text{total available measure achievement points}} = \text{quality performance category percent score}$$

CMS also finalizes its proposal that measure bonus points may be included in the calculation of the quality performance category percent score regardless of whether the measure is included in the calculation of the total measure achievement points.

Quality Measure Benchmarks

CMS did not propose to change the policies on quality measure benchmarking finalized in the 2017 QPP final rule.

Floor for Scored Quality Measures

For the 2018 MIPS performance period, CMS finalizes its proposal to again apply a 3-point floor for each measure that can be reliably scored against a benchmark based on the baseline period, and to amend §414.1380(b)(1) accordingly.

Additional Policies for the CAHPS for MIPS Measure Score

Table 17 in the final rule (reproduced below) summarizes the SSMs included in the CAHPS for MIPS survey and illustrates application of CMS' policy to score only 8 measures.

Table 17: Newly Finalized SSM for CAHPS for MIPS Scoring

Summary Survey Measure	Newly Finalized for Inclusion in the CAHPS for MIPS Survey?	Newly Finalized for Inclusion in CAHPS for MIPS Scoring?
Getting Timely Care, Appointments, and Information	Yes	Yes
How Well Providers Communicate	Yes	Yes
Patient's Rating of Provider	Yes	Yes
Health Promotion & Education	Yes	Yes
Shared Decision Making	Yes	Yes
Stewardship of Patient Resources	Yes	Yes
Courteous and Helpful Office Staff	Yes	Yes
Care Coordination	Yes	Yes
Health Status and Functional Status	Yes	No
Access to Specialists	Yes	No

Identifying and Assigning Measure Achievement Points for Topped Out Measures

CMS did not propose to remove topped out measures for the 2018 MIPS performance period because it recognizes that there are currently a large number of topped out measures; their removal could impact the ability of some MIPS eligible clinicians to submit 6 measures; and their removal could impact some specialties more than others.

CMS finalizes a proposed timeline (described below) for removing topped out measures in future years.

CMS finalizes a proposal to apply a special scoring cap to topped out measures with a scoring cap of 7 points, rather than the proposed 6 points. CMS believes this simple approach can easily be predicted by clinicians, and will create incentives for clinicians to submit other measures for which they can improve and earn future improvement points.

CMS finalizes its proposal to apply the special topped out scoring method for the 2018 performance period to only 6 measures for the 2018 performance period, provided they are again identified as topped out in the benchmarks for the 2018 performance period. CMS believes this special scoring approach would not overwhelm any one specialty and would provide additional

time to evaluate the impact of topped out measures before applying the special topped out scoring to all topped out measures for the 2019 performance period. Table 18 in the final rule (reproduced here) details the topped-out measure for special scoring for the 2018 MIPS performance period.

Table 18: Topped Out Measures Proposed for Special Scoring for the 2018 MIPS Performance Period

Measure Name	Measure ID	Measure Type	Topped Out for All Submission Mechanisms	Specialty Set
Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin	21	Process	Yes	General Surgery, Orthopedic Surgery, Otolaryngology, Thoracic Surgery, Plastic Surgery
Melanoma: Overutilization of Imaging Studies in Melanoma	224	Process	Yes	Dermatology
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	23	Process	Yes	General Surgery, Orthopedic Surgery, Otolaryngology, Thoracic Surgery, Plastic Surgery
Image Confirmation of Successful Excision of Image-Localized Breast Lesion	262	Process	Yes	n/a
Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description	359	Process	Yes	Diagnostic Radiology
Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy	52	Process	Yes	n/a

CMS provides the following lifecycle for scoring and removing topped out measures as follows (starting with the 2017 MIPS performance period as an example).

Year 1	Measure benchmarks are identified as topped out for the 2017 MIPS performance period.
Year 2	Measure benchmarks are identified as topped out for the 2018 MIPS performance period. Measures identified in Table 18 would have special scoring applied, provided they are identified as topped out for the second consecutive year
Year 3	Measure benchmarks are identified as topped out in the benchmarks published for the 2019 MIPS performance period. The measures identified as topped out in the benchmarks published for the 2019 MIPS performance period and the previous two consecutive performance periods would continue to have special scoring applied for the 2019 MIPS performance period and would be considered, through notice-and-comment rulemaking, for removal for the 2020 MIPS performance period.
Year 4	Topped out measures that are finalized for removal are no longer available for reporting.

CMS finalizes its proposed policy that it will not apply the topped out measure cap to measures in the CMS Web Interface for the QPP. CMS also notes that because the Shared Savings Program incorporates a methodology for measures with high performance into the benchmark, it does not believe capping benchmarks from the CMS Web Interface for the QPP is appropriate.

Table 19 in the final rule provides an example that illustrates the scoring impact of topped out measures.

Case Minimum Requirements and Measure Reliability and Validity

As background, in the 2017 QPP final rule, CMS finalized a 20-case minimum for all quality measures except the all-cause hospital readmission measure, which has a 200-case minimum requirement for groups of 16 or more. CMS did not propose any changes to this requirement.

CMS finalized policies in the 2017 QPP final rule for two classes of measures for the transition year. Class 1 measures are measures that can be scored based on performance because they have a benchmark, meet the case minimum requirement, and meet the data completeness standard. Class 1 measures would receive 3 to 10 points based on performance compared to the benchmark.

Class 2 measures are measures that cannot be scored based on performance because they do not have a benchmark, do not have at least 20 cases, or the submitted measure does not meet data completeness criteria. Class 2 measures, which do not include measures submitted with the CMS Web Interface or administrative claims-based measures, receive 3 points.

CMS proposed to maintain the policy to assign 3 points for measures that are submitted but do not meet the required case minimum or do not have a benchmark for the 2020 MIPS payment year and amend §414.1380(b)(1)(vii) accordingly. CMS proposed a change to the policy for scoring measures that do not meet the data completeness requirement for the 2020 MIPS payment year. Specifically, CMS proposed that in the 2020 MIPS payment year, measures that do not meet data completeness standards will receive 1 point instead of the 3 points that were awarded in the 2019 MIPS payment year.

CMS proposed an exception to the proposed policy for small practices. CMS proposed that, measures submitted by small practices, as defined in §414.1305, and that do not meet data completeness would continue to receive 3 points.

In brief, CMS finalizes its proposal to assign 3 points for measures that are submitted but do not meet the required case minimum or do not have a benchmark for the 2020 MIPS payment year and amends §414.1380(b)(1)(vii) accordingly. CMS also finalizes its policy to assign 1 point to measures that do not meet data completeness criteria, with an exception for measures submitted by small practices, which will receive 3 points.

Scoring for MIPS Eligible Clinicians that Do Not Meet Quality Performance Category Criteria

In the 2017 QPP final rule, CMS finalized that MIPS eligible clinicians who fails to submit a measure that is required to satisfy the quality performance category submission criteria would receive zero points for that measure. CMS did not propose any changes to the policy in the 2018 QPP proposed rule. CMS also did not propose any changes to apply a process to validate whether MIPS eligible clinicians that submit measures via claims and registry submissions have measures available and applicable. Furthermore, CMS states it would not conduct a validation process because it expects these MIPS eligible clinicians to have sufficient measures available to meet the quality performance category requirements.

CMS recognizes that in extremely rare instances there may be a MIPS eligible clinician who may not have available and applicable quality measures. If CMS is not able to score the quality performance category, CMS stated it may reweight their score according to the reweighting policies described in section II.C.7.b.(3)(b) and II.C.7.b.(3)(d) of the final rule.

CMS finalizes its validation proposal with modification beginning with year 3 (2019 performance period and 2021 MIPS payment year). For year 2, (2018 performance period and 2020 MIPS payment year), CMS will continue to apply the year 1 validation process. CMS modifies its validation proposal to provide that it will validate the availability and applicability of quality measures only with respect to the data submission mechanism(s) that a MIPS eligible clinician utilizes for the quality performance category for a performance period.

Incentives to Report High Priority Measures

CMS finalized in the 2017 QPP final rule that it would award 2 bonus points for each outcome or patient experience measure and 1 bonus point for each additional high priority measure that is reported provided that the measure has a performance rate greater than zero, and the measure meets the case minimum and data completeness requirements. CMS defined high priority measures as outcome, appropriate use, patient safety, efficiency, patient experience and care coordination measures (see Tables A and E in the Appendix of the 2017 QPP final rule (81 *FR* 77558 and 77686)). CMS also finalized that it will apply measure bonus points for the CMS Web Interface for the QPP based on the finalized set of measures reportable through that submission mechanism.

CMS did not propose any changes to these policies for awarding measure bonus points for reporting high priority measures. CMS also did not propose any changes to the cap on measure bonus points for reporting high priority measures. CMS finalized in the 2017 QPP final rule a cap on high priority measure bonus points at 10 percent of the denominator (total possible measure achievement points the MIPS eligible clinician could receive in the quality performance category) of the quality performance category for the first 2 years of MIPS.

Incentives to Use CEHRT to Support Quality Performance Category Submissions

In the 2017 QPP final rule, CMS codified 1 bonus point is available for each quality measure submitted with end-to-end electronic reporting, under certain criteria. CMS also finalized a

policy capping the number of bonus points available for electronic end-to-end reporting at 10 percent of the denominator of the quality performance category percent score, for the first 2 years of the program (81 FR 77297). In addition, CMS finalized that the CEHRT bonus would be available to all submission mechanisms except claims submissions.

CMS did not propose changes to these policies related to bonus points for using CEHRT for end-to-end reporting in this proposed rule.

Calculating Total Measure Achievement and Measure Bonus Points

In this section, CMS discusses its proposed refinements to address the ability for MIPS eligible clinicians to submit quality data via multiple submission mechanisms.

Calculating Total Measure Achievement and Measure Bonus Points for Non-CMS Web Interface Reporters

In the CY 2017 QPP final rule, CMS finalized that if a MIPS eligible clinician elects to report more than the minimum number of measures to meet the MIPS quality performance category criteria, then CMS will only include the scores for the measures with the highest number of assigned points, once the first outcome measure is scored, or if an outcome measure is not available, once another high priority measure is scored. CMS did not propose any changes to the policy to score the measures with the highest number of assigned points.

CMS proposed, beginning with the 2018 MIPS performance period, a method to score quality measures if a MIPS eligible clinician submits measures via more than one of the following submission mechanisms: claims, qualified registry, EHR or QCDR submission options. CMS did not finalize this proposal for 2018, but did finalize this policy beginning with the 2019 MIPS performance period.

Consistent with the rest of MIPS, CMS stated it would only score measures within a single identifier. Measures can only be scored across multiple mechanisms if reported by the same individual MIPS eligible clinician, group, virtual group or APM Entity. CMS clarified in the proposed rule that it is not proposing to aggregate measure results across different submitters to create a single score for an individual measure (for example, CMS is not going to aggregate scores from different TINs within a virtual group TIN to create a single virtual group score for the measures; rather, virtual groups must perform that aggregation across TINs prior to data submission to CMS).

Table 21 (reproduced here) summarizes the submission mechanisms and which quality measures can be scored across multiple mechanisms.

Table 21: Scoring Allowed Across Multiple Mechanisms by Submission Mechanism (Determined by MIPS Identifier and Submission Mechanism)

MIPS Identifier and Submission Mechanisms	When can quality measures be scored across multiple mechanisms?
Individual eligible clinician reporting via claims, EHR, QCDR, and registry submission options	Can combine claims, EHR, QCDR, and registry.
Group reporting via EHR, QCDR, registry, and the CAHPS for MIPS survey	Can combine EHR, QCDR, registry, and CAHPS for MIPS survey.
Virtual group reporting via EHR, QCDR, registry, and the CAHPS for MIPS survey	Can combine EHR, QCDR, registry, and CAHPS for MIPS survey.
Group reporting via CMS Web Interface	Cannot be combined with other submission mechanisms, except for the CAHPS for MIPS survey.
Virtual group reporting via CMS Web Interface	Cannot be combined with other submission mechanisms, except for the CAHPS for MIPS survey.
Individual or group reporting facility-based measures	Cannot be combined with other submission mechanisms.
MIPS APMs reporting Web Interface or other quality measures	MIPS APMs are subject to separate scoring standards and cannot be combined with other submission mechanisms.

CMS discusses how measures will be scored:

- If a MIPS eligible clinician submits the same measure via 2 different submission mechanisms, CMS would score each mechanism by which the measure is submitted for achievement and take the highest measure achievement points of the 2 mechanisms.
- CMS would calculate total measure achievement points by using the measures with the 6 highest measure achievement points across multiple submission mechanisms.
- Measure bonus points for high priority measures would be added for all measures submitted via all the different submission mechanisms available, even if more than 6 measures are submitted, but high priority measure bonus points are only available once for each unique measure (as noted by the measure number) that meets the criteria for earning the bonus point.
- If the same measure was submitted through multiple submission mechanisms, CMS would apply the bonus points only once to the measure. If the same measure (as determined by measure ID) is submitted, then CMS would use the highest achievement points for that measure.

Table 22 in the final rule provides an example illustrating assignment of total achievement and bonus points where measures are submitted across multiple submission mechanisms.

CMS is not finalizing, for the 2018 performance period, the policy for calculating the total achievement points and bonus points when using multiple submission mechanisms, but it is

finalizing it for the 2019 performance period and future. This is consistent with its decision not to finalize its proposal to score multiple mechanisms in 2018, but instead begin this for the 2019 performance period.

CMS finalizes its proposal to calculate the total measure achievement and bonus points when using multiple submission mechanisms proposals for year 3 to align with the multiple submission mechanisms policy which will be finalized for year 3.

Calculating Total Measure Achievement and Measure Bonus Points for CMS Web Interface Reporters

With respect to submitting information through a CMS Web Interface, CMS finalized in the 2017 QPP final rule that those who report through the CMS Web Interface are required to report 14 measures, 13 individual measures, and a 2-component measure for diabetes (81 *FR* 77302-77305). In addition, CMS finalized a global floor of 3 points for all CMS Web Interface measures submitted in the transition year, even with measures at zero percent performance rate, provided that these measures have met the data completeness criteria, have a benchmark and meet the case minimum requirements.

Also in the 2017 QPP proposed rule, CMS proposed to continue to assign 3 points for measures with performance below the 30th percentile, provided the measure meets data completeness, has a benchmark, and meets the case minimum requirements for the 2018 MIPS performance year.

CMS notes that in the proposed rule it was not proposing any changes to its previously finalized policy to exclude from scoring CMS Web Interface measures that are submitted but that do not meet the case minimum requirement or that lack a benchmark, or to its policy that measures that are not submitted and measures submitted below the data completeness requirements will receive a zero score. CMS also did not propose any changes to calculating the total measure achievement points and measure bonus points for CMS Web Interface measures.

CMS finalizes its proposal to not score CMS Web Interface measures redesignated as pay for reporting by the Shared Savings Program. CMS also clarifies that groups that submit measures via the CMS Web Interface may also submit and be scored on CMS-approved survey vendor for CAHPS for MIPS submission options. In addition, groups of 16 or more eligible clinicians that meet the case minimum for administrative claims measures will automatically be scored on the all-cause hospital readmission measure and have that measure score included in their quality category performance percent score.

(3) Scoring Improvement for the MIPS Quality Performance Category Percent Score

CMS finalizes its proposal to define an improvement percent score to mean the score that represents improvement for the purposes of calculating the quality performance category score. CMS also finalizes as proposed that an improvement percent score would be assessed at the quality performance category level and included in the calculation of the quality performance category percent score. CMS finalizes that the improvement percent score may not total more

than 10 percentage points.

Data Sufficiency Standard to Measure Improvement for Quality Performance Category

MACRA stipulates that beginning with the second year to which the MIPS applies, if data sufficient to measure improvement is available, then CMS shall measure improvement for the quality performance category. Measuring improvement requires a direct comparison of data from one QPP year to another.

CMS finalizes that improvement scoring is available when the data sufficiency standard is met which means when data are available and a MIPS eligible clinician has a quality performance category achievement percent score for the previous performance period and the current performance period.

CMS also finalizes that data must be comparable to meet the requirement of data sufficiency, which means a quality performance category achievement percent score is available for the current and previous performance periods and quality performance category achievement percent scores can be compared.

CMS finalizes its proposal that the quality performance category achievement percent scores are comparable when submissions are received from the same identifier for two consecutive performance periods. If the identifier is not the same for 2 consecutive performance periods, then for individual submissions, the comparable quality performance category achievement percent score is the highest available quality performance category achievement percent score associated with the final score from the prior performance period that will be used for payment for the individual. For group, virtual group, and APM Entity submissions, the comparable quality performance category achievement percent score is the average of the quality performance category achievement percent score associated with the final score from the prior performance period that will be used for payment for each of the individuals in the group.

Table 23 in the final rule (reproduced below) summarizes the different cases when a group or individual will be eligible for improvement scoring.

Scenario	Current MIPS Performance Period Identifier	Prior MIPS Performance Period Identifier (with score greater than zero)	Eligible for Improvement Scoring	Data Comparability
No change in identifier.	Individual (TIN A/NPI 1)	Individual (TIN A/NPI 1)	Yes	Current individual score is compared to individual score from prior performance period.
No change in identifier.	Group (TIN A)	Group (TIN A)	Yes	Current group score is compared to group score from prior performance period.

Scenario	Current MIPS Performance Period Identifier	Prior MIPS Performance Period Identifier (with score greater than zero)	Eligible for Improvement Scoring	Data Comparability
Individual is with same group, but selects to submit as an individual whereas previously the group submitted as a group.	Individual (TIN A/ NPI 1)	Group (TIN A)	Yes	Current individual score is compared to the group score associated with the TIN/NPI from the prior performance period.
Individual changes practices, but submitted to MIPS previously as an individual.	Individual (TIN B/NPI)	Individual (TIN A/NPI)	Yes	Current individual score is compared to the individual score from the prior performance period.
Individual changes practices and has multiple scores in prior performance period.	Individual (TIN C/NPI)	Group (TIN A/NPI); Individual (TIN B/NPI)	Yes.	Current individual score is compared to highest score from the prior performance period.
Group does not have a previous group score from prior performance period.	Group (TIN A)	Individual scores (TIN A/NPI 1, TIN A/NPI 2, TIN A/NPI 3, etc.)	Yes	The current group score is compared to the average of the scores from the prior performance period of individuals who comprise the current group.
Virtual group does not have previous group score from prior performance period.	Virtual Group (Virtual Group Identifier A) (Assume virtual group has 2 TINs with 2 clinicians.)	Individuals (TINA/NPI 1, TIN A/NPI 2, TIN B/NPI 1, TIN B/NPI 2)	Yes	The current group score is compared to the average of the scores from the prior performance period of individuals who comprise the current group.
Individual has score from prior performance period as part of an APM Entity	Individual (TIN A/NPI 1)	APM Entity (APM Entity Identifier)	Yes	Current individual score is compared to the score of the APM entity from the prior performance period.

Scenario	Current MIPS Performance Period Identifier	Prior MIPS Performance Period Identifier (with score greater than zero)	Eligible for Improvement Scoring	Data Comparability
Individual does not have a quality performance category achievement score for the prior performance period.	Individual (TIN A/NPI 1)	Individual was not eligible for MIPS and did not voluntarily submit any quality measures to MIPS.	No	The individual quality performance category score is missing for the prior performance period and not eligible for improvement scoring.

Additional Requirements for Full Participation to Measure Improvement for Quality Performance Category

CMS finalizes that MIPS eligible clinicians must fully participate in the current performance year. CMS states its belief that improvement is most meaningful and valid when it has a full set of quality measures. For example, for MIPS eligible clinicians submitting via QCDR, full participation would generally mean submitting 6 measures including 1 outcome measure if an outcome measure is available or 1 high priority measure if an outcome measure is not available, and meeting the 60 percent data completeness criteria for each of the 6 measures.

CMS is also finalizing that the quality improvement percent score is zero if the clinician did not fully participate in the quality performance category for the current performance period.

CMS is also finalizing that if a MIPS eligible clinician has a previous year quality performance category score less than or equal to 30 percent, CMS would compare 2018 performance to an assumed 2017 quality performance category achievement percent score of 30 percent. CMS believes this approach appropriately recognizes the participation of MIPS eligible clinicians who participated in the transition year and accounts for MIPS eligible clinicians who participated minimally and may otherwise be awarded for an increase in participation rather than an increase in achievement performance.

Measuring Improvement Based on Changes in Achievement

To calculate improvement with a focus on quality performance, CMS proposed to focus on improvement based on achievement performance and would not consider measure bonus points. CMS believes that improvement points should be awarded based on improvement related to achievement and not awarded for reasons not directly related to performance, such as the use of the end-to-end electronic reporting.

To measure improvement at the quality performance category level, CMS will use the quality performance achievement percent score, excluding measure bonus points (and any improvement score) for the applicable years. This “quality performance category achievement percent score” is calculated using the following formula:

Quality performance category achievement percent score = total measure achievement points/total available measure achievement points.

CMS would compare the current score on this measure to the previous period score. If the current score is higher, the MIPS eligible clinician may qualify for an improvement percent score to be added into the quality performance category percent score for the current performance year. Table 27 of the proposed rule (82 FR 30117) illustrated how the quality performance category achievement percent score is calculated.

CMS finalizes that improvement scoring is available to MIPS eligible clinicians that demonstrate improvement in performance in the current MIPS performance period compared to the performance in the previous MIPS performance period, based on measure achievement points.

Improvement Scoring Methodology for the Quality Performance Category

CMS finalizes its proposal to award an “improvement percent score” based on the following formula:

Improvement percent score = (increase in quality performance category achievement percent score from prior performance period to current performance period / prior performance period quality performance category achievement percent score)*10 percent.

Under the final rule, the improvement percent score cannot be negative (that is, lower than zero percentage points). The improvement percent score would be zero for those who do not have sufficient data or who are not eligible under its proposal for improvement points.

CMS also finalizes its proposal to cap the size of the improvement award at 10 percentage points, which it believes appropriately rewards improvement and does not outweigh percentage points available through achievement. In effect, 10 percentage points under this formula would represent 100 percent improvement – or doubling of achievement measure points – over the immediately preceding period.

Table 24: Improvement Scoring Examples Based on Rate of Increase in Quality Performance Category Achievement Percent Scores

	Year 1 Quality Performance Category Achievement Percent Score	Year 2 Quality Performance Category Achievement Percent Score	Increase in Improvement	Rate of improvement	Improvement Percent Score

Individual Eligible Clinician #1 (Pick your Pace Test Option)	5% (Will substitute 30% which is the lowest score a clinician can achieve with complete reporting in year 1.)	50%	20% Because the year 1 score is below 30%, CMS measures improvement above 30%.	$20\%/30\%=0.67$	$0.67*10\% = 6.7\%$ No cap needed.
Individual Eligible Clinician #2	60%	66%	6%	$6\%/60\%=0.10$	$0.10*10\% = 1.0\%$ No cap needed
Individual Eligible Clinician #3	90%	93%	3%	$3\%/90\%=0.033$	$0.033*10\% = 0.3\%$ No cap needed
Individual Eligible Clinician #4	30%	70%	40%	$40\%/30\%=1.33$	$1.33*10\%=13.3\%$ Apply cap at 10%

Calculating the Quality Performance Category Percent Score Including Improvement

CMS finalizes its proposal to incorporate the improvement percent score into the quality performance category percent score.

The formula is: **Quality performance category percent score = ([total measure achievement points + measure bonus points]/total available measure achievement points) + improvement percent score.**

The total cannot exceed 100 percent.

The same formula and logic will be applied for both CMS Web Interface and Non-CMS Web Interface reporters. Table 31 of the proposed rule (82 *FR* 30120) provides an illustrative example.

(4) Scoring the Cost Performance Category

CMS finalizes its proposal to continue its policies for scoring the cost performance category and refers readers to the 2017 QPP final rule for more detail (81 *FR* 77308-77311). CMS finalizes a number of changes in this rule. In brief, CMS finalizes its proposal to add improvement scoring to the cost performance category scoring methodology starting with the 2020 MIPS payment year. A MIPS eligible clinician's cost performance category percent score is the sum of the following, not to exceed 100 percent: the total number of achievement points earned by the MIPS eligible clinician divided by the total number of available achievement points (which can be expressed as a percentage); and the cost improvement score. CMS will not calculate a cost performance category score if a MIPS eligible clinician or group is not attributed any cost measures because the MIPS eligible clinician or group has not met the case minimum requirements for any of the cost measures or a benchmark has not been created for any of the cost measures that would otherwise be attributed to the clinician or group.

Measuring Improvement

Calculating Improvement at the Cost Measure Level. For the cost performance category, similar to the quality performance category, CMS finalizes its proposal that improvement scoring is available to MIPS eligible clinicians and groups that demonstrate improvement in performance in the current MIPS performance period compared to their performance in the immediately preceding MIPS performance period.

CMS finalizes its proposal to measure cost improvement at the measure level for the cost performance category. CMS notes that the cost performance category is not subject to the same issues of measure selection as the quality performance category, given that cost measures are calculated based on Medicare administrative claims data maintained by CMS without any additional data input from or reporting by clinicians. MIPS eligible clinicians are also not given the opportunity to select which cost measures apply to them.

CMS finalizes a different data sufficiency standard for the cost performance category than for the quality performance category. Specifically, CMS will calculate a cost improvement score only when data sufficient to measure improvement is available. CMS finalizes its proposal that sufficient data will be available when a MIPS eligible clinician participates in MIPS using the same identifier in 2 consecutive performance periods and is scored on the same cost measure(s) for 2 consecutive performance periods (for example, in the 2017 MIPS performance period and the 2018 MIPS performance period). If the cost improvement score cannot be calculated because sufficient data are not available, CMS will assign a cost improvement score of zero percentage points.

Improvement Scoring Methodology. CMS finalizes its proposal to quantify improvement in the cost performance category by comparing the number of cost measures with significant improvement in performance and the number of cost measures with significant declines in performance. Specifically, CMS finalizes to determine the cost improvement score by subtracting the number of cost measures with significant declines from the number of cost measures with significant improvement, and then dividing the result by the number of cost measures for which the MIPS eligible clinician or group was scored in both performance periods, and then multiplying the result by the maximum cost improvement score. For the 2020 MIPS payment year, improvement scoring will be possible for the total per capita cost measure and the MSPB measure. These are the 2 measures available for 2 consecutive performance periods. The cost improvement score under this methodology can only be a positive amount.

CMS finalizes the maximum cost improvement score available in the cost performance category would be 1 percentage point out of 100 percentage points. For example, if a clinician were measured on 2 measures consistently, improved significantly on one, and did not show significant improvement on the other (as measured by the t-test method described above), the clinician would receive 0.5 improvement percentage points.

Calculating the Cost Performance Category Percent Score with Achievement and Improvement

CMS finalizes its proposal to add improvement to an existing category percent score for the cost performance category. This is the same approach CMS finalized for the quality performance

category. CMS believes this is the most straightforward and simple way to incorporate improvement.

The formula is: **(Cost Achievement Points/Available Cost Achievement Points) + (Cost Improvement Score) = (Cost Performance Category Percent Score).**

The total cannot exceed 100 percent.

CMS provides an example in Table 25 (reproduced below) in the final rule. This example is for group reporting where the group is measured on both the total per capita cost measure and the MSPB measure for 2 consecutive performance periods. CMS also uses the maximum cost improvement score of 1.

TABLE 25: Example of Assessing Achievement and Improvement in the Cost Performance Category

Measure	Measure achievement points earned by the group	Total Possible Measure Achievement Points	Significant Improvement from Prior Performance Period	Significant Decline from Prior Performance Period
Total per Capita Cost Measure	8.2	10	Yes	No
MSPB Measure	6.4	10	No	No
Total	14.6	20	N/A	N/A

In this example, there are 20 total possible measure achievement points and 14.6 measure achievement points earned by the group, and the group improved on one measure but not the other, with both measures being scored in each performance period. The cost improvement score would be determined as follows: ((1 measure with significant improvement – zero measures with significant decline)/2 measures) * 1 percentage point = 0.5 percentage points. Under the revised formula, the cost performance category percent score would be

$$(14.6/20) + 0.5\% = 73.5\%.$$

The cost performance category percent score would then be multiplied by the cost performance category weight. This group would have 73.5 percent x 10 percent x 100 = 7.35 points for the cost performance category contributed towards the final score.

(5) Facility-Based Measures Scoring Option for the 2020 MIPS Payment Year for the Quality and Cost Performance Categories

Facility-Based Measurement

CMS proposed for the 2020 MIPS payment year to include all the measures adopted for the FY 2019 Hospital VBP Program on the MIPS list of quality measures and cost measures. Under this proposal, CMS considers the FY 2019 Hospital VBP Program measures to meet the definition of

additional system-based measures provided MACRA. CMS also proposes that facility-based measures available for the 2018 MIPS performance period are the measures adopted for the FY 2019 Hospital VBP Program year. CMS notes that measures in the FY 2019 Hospital VBP Program have different performance periods.

After consideration of comments received, CMS finalizes its proposal on the general availability of facility-based measurement with the modification that facility-based measurement will not be available for clinicians until the 2019 MIPS performance period/2021 MIPS payment year.

Facility-Based Measurement Applicability

CMS finalizes its proposal that a MIPS eligible clinician is eligible for facility-based measurement under MIPS if they are determined facility-based as an individual. CMS further finalizes its proposal that a MIPS eligible clinician is considered facility-based as an individual if the MIPS eligible clinician furnishes 75 percent or more of their covered professional services in sites of service identified by certain POS codes. This is limited to an inpatient hospital setting as identified by POS code 21, or an emergency room, as identified by POS code 23, based on claims for a period prior to the performance period as specified by CMS.

CMS did not propose to include POS code 22 in determining whether a clinician is facility-based because many clinicians who bill for services using this POS code may work on a hospital campus but in a capacity that has little to do with the inpatient care in the hospital.

Clinicians will be determined to be facility-based through an evaluation of covered professional services between September 1 of the calendar year 2 years preceding the performance period through August 31 of the calendar year preceding the performance period with a 30-day claims run out. For the 2021 MIPS payment year CMS would use the data available at the end of October 2018 to determine whether a MIPS eligible clinician is considered facility-based by its definition.

Facility-Based Measurement Group Participation. CMS finalizes its proposal that a MIPS eligible clinician is eligible for facility-based measurement under MIPS if they are determined facility-based as part of a group. CMS also finalizes that a facility-based group is a group in which 75 percent or more of the MIPS eligible clinician NPIs billing under the group's TIN are eligible for facility-based measurement as individuals.

CMS notes that facility-based measurement will not be available until the 2019 MIPS performance period/2021 payment year so a facility-based group will not exist before that time.

Facility Attribution for Facility-Based Measurement

CMS finalizes its proposal that MIPS eligible clinicians who elect facility-based measurement would receive scores derived from the VBP score for the facility at which they provided services for the most Medicare beneficiaries. This would be derived based on the period of September 1 of the calendar year 2 years preceding the performance period through August 31 of the calendar year preceding the performance period with a 30-day claims run out. In cases in which there is

an equal number of Medicare beneficiaries treated at more than one facility, CMS will use the VBP score from the facility with the highest score.

Election of Facility-Based Measurement

CMS agreed with stakeholders that facility-based measurement should be a voluntary process. Individual MIPS eligible clinicians or groups who wish to have their quality and cost performance category scores determined based on a facility's performance must elect to do so.

CMS does not finalize either its proposal or its alternative option for how an individual clinician or group will elect to use and be identified as using facility-based measurement for the MIPS program. Because of the delay in offering facility-based measurement, CMS stated it will use the additional time to examine the attestation process it proposed and the alternative opt-out process.

Facility-Based Measures

CMS notes that because of its decision to delay the facility-based measure until the 2019 MIPS performance period, CMS will propose in next year's rulemaking the facility measures that will be used for purposes of the 2019 MIPS performance year. CMS notes that it believes that to better align incentives between clinicians and hospitals, it elected to use measures developed and implemented in other programs and recognizes that the periods are not perfectly aligned. CMS states that it will consider ways to align performance periods between the Hospital VBP program and the QPP in the future.

Scoring Facility-Based Measurement

CMS believes that the Hospital VBP Program represents the most appropriate value-based purchasing program with which to begin implementation of the facility-based measurement option under MIPS. CMS considered several methods to incorporate facility-based measures into scoring for the 2020 MIPS payment year, including selecting hospitals' measure scores, domain scores, and the Hospital VBP Program Total Performance Scores to form the basis for the cost and quality performance category scores for individual MIPS eligible clinicians and groups that are eligible to participate in facility-based measurement.

CMS proposed that facility-based scoring be available for the quality and cost performance categories and that the facility-based measurement scoring standard is the MIPS scoring methodology applicable for those who meet facility-based eligibility requirements and who elect facility-based measurement. CMS also proposed that the benchmarks for facility-based measurement are those that are adopted under the value-based purchasing program of the facility for the year specified.

CMS proposes that the quality performance category score for facility-based measurement is reached by determining the percentile performance of the facility determined in the value-based purchasing program for the specified year and awarding a score associated with that same percentile performance in the MIPS quality performance category score for those clinicians who are not scored using facility-based measurement. Likewise, CMS proposes that the cost

performance category score for facility-based measurement is established by determining the percentile performance of the facility determined in the VBP program for the specified year and awarding the number of points associated with that same percentile performance in the MIPS cost performance category score for those clinicians who are not scored using facility-based measurement.

CMS finalizes its proposed methodology applying Hospital VBP Program scoring to MIPS quality and cost performance categories with modifications. Given the delay in implementation of facility-based measurement. CMS stated that it will identify the specifics of the Hospital VBP Program performance and scoring to be used for facility-based measurement in MIPS in future rulemaking.

CMS also finalizes that benchmarks for facility-based measurement are those that are adopted under the VBP program of the facility for the year specified.

CMS also finalizes its proposal to determine the percentile performance of the facility determined for the specified year and awarding a score associated with that same percentile performance in the MIPS quality performance category score and MIPS cost performance category score for those clinicians who are not scored using facility-based measurement. Given the one-year delay in facility-based measurement, CMS is not finalizing use of the FY 2019 Hospital VBP Program measurement and scoring.

Scoring Improvement for Facility-Based Measurement

CMS states that for those who may be measured under facility-based measurement, improvement is already captured in the scoring method used by the Hospital VBP Program. A hospital that demonstrated improvement in the individual measures, for example, would in turn receive a higher score through the Hospital VBP Program methodology, so that improvement is reflected in the underlying Hospital VBP Program measurement. Moreover, CMS stated that improvement is already captured in the distribution of MIPS performance scores that is used to translate Hospital VBP Total Performance Score into a MIPS quality performance category score. Moreover, eligible clinicians who elect facility-based measurement would not be eligible for a cost improvement score in the cost performance category under its proposed methodology because they would not be scored on the same cost measure(s) for 2 consecutive performance periods.

CMS finalizes its proposal that a clinician or group participating in facility-based measurement would not be given the opportunity to earn improvement points based on prior performance in the MIPS quality and cost performance categories.

Bonus Points for Facility-Based Measurement

CMS finalizes its proposal to not award bonus points for additional high priority and end-to-end electronic reporting for clinicians scored under facility-based measurement.

(6) Scoring the Improvement Activities Performance Category

CMS did not propose any changes to the scoring of the improvement activities performance category. This includes no changes to the scoring of the patient-centered medical home or comparable specialty practice – though CMS did propose a change to how groups qualify for this activity.

CMS finalizes its proposal to no longer require these self-identifications for non-patient facing MIPS eligible clinicians, small practices, practices located in rural areas or geographic HPSAs, or any combination thereof, beginning with the 2018 MIPS performance period and for future years.

(7) Scoring the Advancing Care Information Performance Category

CMS refers readers to section II.C.6.f. of the final rule where scoring for the advancing care information performance category is discussed.

b. Calculating the Final Score

With respect to calculating the final score, CMS proposed to add a complex patient scoring bonus and add a small practice bonus to the final score. In addition, CMS reviewed the final score calculation for the 2020 MIPS payment year and proposed refinements to the reweighting policies.

(1) Accounting for Risk Factors

(a) Complex Patient Bonus

CMS finalizes its proposal to implement a short-term strategy for the QPP to address the impact patient complexity may have on final scores. CMS finalizes its proposal that the bonus only apply for the 2018 MIPS performance period (2020 MIPS payment year) and will assess on an annual basis.

For the 2020 MIPS payment year, CMS modifies its proposal to base the complex patient bonus based on the average HCC risk score. Instead, CMS finalizes a policy to calculate the complex patient bonus for MIPS eligible clinicians and groups by adding the average HCC risk score to the dual eligible ratio, based on full benefit and partial benefit dual eligible beneficiaries, multiplied by 5. Furthermore, CMS finalizes its proposal to add a complex patient bonus to the final score for the 2020 MIPS payment year for MIPS eligible clinicians that submit data (as explained below) for at least one performance category. The specifics are as follows:

- HCC risk scores will be calculated using the model adopted under section 1853 of the Act for Medicare Advantage risk adjustment purposes.
- HCC risk scores will be an average of the MIPS eligible clinician or clinicians in the group.

- The time period for purposes of average HCC risk scores will span from the last 4 months of a calendar year 1 year prior to the performance period followed by the first 8 months of the performance period in the next calendar year (September 1, 2017 to August 31, 2018 for the 2018 MIPS performance period).
- A dual eligible ratio (including both full and partial Medicaid beneficiaries) for each MIPS eligible clinician will be based on the proportion of unique patients who have dual eligible status seen by the MIPS eligible clinician among all unique patients.

CMS finalizes its proposal to calculate the average HCC risk score for a MIPS eligible clinician or group by averaging HCC risk scores for beneficiaries cared for by the MIPS eligible clinician or clinicians in the group during the second 12-month segment of the eligibility period, which spans from the last 4 months of a calendar year 1 year prior to the performance period followed by the first 8 months of the performance period in the next calendar year (September 1, 2017 to August 31, 2018 for the 2018 MIPS performance period).

HCC risk scores for beneficiaries will be calculated based on the year immediately prior to the performance period. For the 2018 MIPS performance period, the HCC risk scores will be calculated based on beneficiary services from the 2017 year. This is the same approach CMS uses to set Medicare Advantage rates prospectively each year, and CMS believes this approach mitigates the risk of “upcoding” to get higher expected costs.

For MIPS APMs and virtual groups, CMS finalizes to calculate the complex patient bonus as follows: [the beneficiary weighted average HCC risk score for all MIPS eligible clinicians, and if technically feasible, TINs for models and virtual groups which rely on complete TIN participation within the APM entity or virtual group, respectively] + [the average dual eligible ratio for all MIPS eligible clinicians, and if technically feasible, TINs for models and virtual groups which rely on complete TIN participation, within the APM entity or virtual group, respectively, x 5].

CMS finalizes a policy that the complex patient bonus cannot exceed 5 points.

To receive the complex patient bonus, CMS finalizes its proposal that the MIPS eligible clinician, group, virtual group or APM Entity must submit data on at least one measure or activity in a performance category during the performance period. Based on its data analysis, CMS estimates that the bonus will range from 2.52 in the first HCC quartile to 3.72 in the highest HCC quartile for all MIPS eligible clinicians.

Small Practice Bonus for the 2020 MIPS Payment Year

To receive the small practice bonus, CMS finalizes its proposal that the MIPS eligible clinician must participate in the program by submitting data on at least one performance category in the 2018 MIPS performance period (the performance category does not need to be the quality performance category). Group practices, virtual groups, or APM Entities that meet the definition of small practice, or a practice consisting of 15 or fewer eligible clinicians may receive a small

practice bonus of 5 points to the final score. Specifically, CMS finalizes at to add a small practice bonus of five points to the final score for MIPS eligible clinicians, groups, APM entities, and virtual groups that meet the definition small practice.

CMS that this small practice bonus is intended to be a short-term strategy to help practices transition to MIPS and thus it is proposing the bonus only for the 2018 MIPS performance period (2020 MIPS payment year). CMS states that it will assess on an annual basis whether to continue the bonus and how the bonus should be structured.

(2) Final Score Calculation

CMS finalizes its proposal to revise the final score calculation to incorporate the addition of the complex patient and small practice bonuses. CMS will use this formula to calculate the final score for all MIPS eligible clinicians, groups, virtual groups, and MIPS APMs starting with the 2020 MIPS payment year.

CMS finalizes its proposal to add that a MIPS eligible clinician with fewer than 2 performance category scores would receive a final score equal to the performance threshold. CMS states this policy is necessary to account for extreme and uncontrollable circumstances which, if finalized, could result in a scenario where a MIPS eligible clinician is not scored on any performance categories.

(3) Final Score Performance Category Weights

This section discusses general weights, the flexibility for weighting performance categories, reweighting because of extreme and uncontrollable circumstances, and redistributing performance category weights.

General Weights

CMS reviews the statutory requirements with respect to the weights (Section 1848(q)(5)(E)(i)) for the performance categories, the policies adopted in the 2017 QPP final rule, and proposals in this rule that affect the weights. The statute specifies the following performance category weights, in general: 30 percent for the quality performance category, 30 percent for the cost performance category, 25 percent for the ACI performance category, and 15 percent for the improvement activities performance category. The statute also provides more flexibility on the weights for the quality and cost performance categories for the first and second years for which the MIPS applies to payments.

CMS maintains the weight of the cost performance category to 10 percent and the weight of the quality performance category to 50 percent for the 2020 MIPS payment year (same as finalized in the 2017 QPP final rule). As specified in statute, the weights for the other performance categories are 25 percent for the ACI performance category and 15 percent for the improvement activities performance category. In the 2018 QPP proposed rule, CMS had proposed to change

the weight of the cost performance category to 0 percent and to change the weight of the quality performance category to 60 percent.

Table 28 in the final rule (reproduced below) summarizes the weights specified for each performance category as specified under statute, and accordance with CMS policies adopted in the 2017 QPP final rule.

TABLE 28: Weights by MIPS Performance Category*

Performance Category	Transition Year	2020 MIPS Payment Year	2021 MIPS Payment Year and Beyond
Quality	60%	50%	30%
Cost	0%	10%	30%
Improvement Activities	15%	15%	15%
Advancing Care Information*	25%	25%	25%

*The weight for advancing care information could decrease (not below 15 percent) starting with the 2021 MIPS payment year if the Secretary estimates that the proportion of physicians who are meaningful EHR users is 75 percent or greater.

Flexibility for Weighting Performance Categories

For the 2020 MIPS payment year, CMS finalizes its proposal to assign a scoring weight of zero percent to a performance category and redistribute its weight to the other performance categories in situations where no measures are available and applicable for that particular performance category or in extreme and uncontrollable circumstances, such as natural disasters. Overall, CMS believes these situations will be rare.

For the quality performance category, CMS believes it will be extremely rare for it to be necessary to assign a scoring weight of zero percent. Based on the volume of measures available to MIPS eligible clinicians via the multiple submission mechanisms, CMS generally believes there will be at least one quality measure applicable and available to every MIPS eligible clinician. CMS acknowledges there could be rare instances where a subset of MIPS eligible clinicians (as well as groups and virtual groups) may have no quality measures available and applicable and for whom it receives no quality performance category submission (and for whom the all-cause hospital readmission measure does not apply). CMS notes that MIPS eligible clinicians that do not submit quality measures when they have them available and applicable would receive a quality performance category percent score of zero percent. CMS may also reweight the quality performance category based on extreme and uncontrollable circumstances as discussed in section II.C.7.b.(3)(c) of the final rule.

For the cost performance category, CMS established a policy that if a MIPS eligible clinician is not attributed a sufficient number of cases for a measure (in other words, has not met the required case minimum for the measure), or if a measure does not have a benchmark, then the measure will not be scored for that clinician. If CMS does not score any cost measures for a

MIPS eligible clinician in accordance with this policy, then the clinician would not receive a cost performance category percent score.

For the improvement activities performance category, barring limited extreme and uncontrollable circumstances, such as natural disasters, CMS did not propose any changes that would affect its ability to calculate an improvement activities performance category score. CMS believes that all MIPS eligible clinicians will have sufficient activities applicable and available.

Extreme and Uncontrollable Circumstances

In the CY 2017 QPP final rule, CMS established a policy allowing a MIPS eligible clinician affected by extreme and uncontrollable circumstances to submit an application to CMS to be considered for reweighting of the ACI performance category under section 1848(q)(5)(F) of the Act. Extreme and uncontrollable circumstances could include, for example, natural disaster in which an EHR or practice location is destroyed.

CMS proposed to extend this policy, beginning with the 2020 MIPS payment year to the quality and cost performance categories. CMS would reweight these performance categories if a MIPS eligible clinician, group, or virtual group's request for a reweighting assessment based on extreme and uncontrollable circumstances is granted.

With respect to the process, CMS proposed the following:

- CMS proposed to adopt the same deadline (December 31, 2018 for the 2018 MIPS performance period) for submission of a reweighting assessment, and encouraged the requests to be submitted on a rolling basis.
- CMS proposed that the reweighting assessment must include the nature of the extreme and uncontrollable circumstance, including the type of event, date of the event, and length of time over which the event took place, performance categories impacted, and other pertinent details that impacted the ability to report on measures or activities to be considered for reweighting of the quality, cost, or improvement activities performance categories (for example, information detailing how exactly the event impacted availability and applicability of measures).

CMS finalizes its proposed policies for reweighting the quality, cost, and improvement activities performance categories based on extreme and uncontrollable circumstances, beginning with the 2018 performance period/2020 MIPS payment year with one minor exception. CMS did not finalize its proposal that a virtual group submitting a reweighting application must have a majority of its TINs impacted by extreme and uncontrollable circumstances in order for the virtual group to qualify for reweighting, but instead it will review each virtual group application on a case-by-case basis and make a determination based on the information provided on the practices impacted and nature of the event.

CMS notes that these policies for reweighting the quality, cost, and improvement activities performance categories based on extreme and uncontrollable circumstances will apply beginning

with the 2018 MIPS performance period/2020 MIPS payment year. For those affected by the recent hurricanes Harvey, Irma, and Maria, CMS is adopting interim final policies for the 2017 performance period/2019 MIPS payment year for MIPS eligible clinicians (discussed in interim final rule with comment period in section III.B).

Redistributing Performance Category Weights

CMS finalizes its reweighting policies as proposed for the 2020 MIPS payment year, with the exception of the policies that assume the cost performance category will be weighted at zero percent, as CMS decided to finalize the cost performance category weight at 10 percent (as described in section II.C.6.d.(2) of this final rule).

Table 29 in the final rule (reproduced below) summarizes the final reweighting policies for the 2018 MIPS performance period and 2020 MIPS payment year.

Table 29: Performance Category Redistribution Policies for the 2020 MIPS Payment Year

Reweighting Scenario	Quality	Cost	Improvement Activities	Advancing Care Information
No Reweighting Needed				
- Scores for all four performance categories	50%	10%	15%	25%
Reweight One Performance Category				
-No Cost	60%	0%	15%	25%
-No Advancing Care Information	75%	10%	15%	0%
-No Quality	0%	10%	45%	45%
-No Improvement Activities	65%	10%	0%	25%
Reweight Two Performance Categories				
-No Cost and no Advancing Care Information	85%	0%	15%	0%
-No Cost and no Quality	0%	0%	50%	50%
-No Cost and no Improvement Activities	75%	0%	0%	25%
-No Advancing Care Information and no Quality	0%	10%	90%	0%
-No Advancing Care Information and no Improvement Activities	90%	10%	0%	0%
-No Quality and no Improvement Activities	0%	10%	0%	90%

8. MIPS Payment Adjustments

a. MIPS Payment Adjustment Identifier and Final Score Used in the MIPS Payment Adjustment Calculation

Background and Clarifications. No changes were proposed to the previously finalized policy for the MIPS payment adjustment identifier, under which a TIN/NPI may receive a final score based on an individual, group, or AMP Entity group performance, but the MIPS payment adjustment will be applied at the TIN/NPI level.

CMS clarifies certain policies regarding the assignment of a final score that were inadvertently not finalized in the 2017 QPP final rule.

- CMS will apply the group final score to all of the TIN/NPI combinations that bill under that TIN during the performance period.
- For individual MIPS eligible clinicians submitting data using TIN/NPI, the final score is the one associated with the TIN/NPI that is used during the performance period.
- For eligible clinicians MIPS APMs, the APM Entity group’s final score will be assigned to all associated APM Entity Participant Identifiers.
- For eligible clinicians that participate in APMs for which the APM scoring standard does not apply, CMS will assign a final score using either the individual or group data submission assignments.
- In the case where a MIPS eligible clinician starts working in a new practice or otherwise establishes a new TIN that did not exist during the performance period and there is no final score for the new TIN/NPI, the NPI’s performance for the TIN(s) that the NPI was billing under during the performance period will be used. If the MIPS eligible clinician has only one final score associated with the NPI from the performance period, then that final score will be used.
- If an NPI bills under multiple TINs in the performance period and bills under a new TIN in the MIPS payment year, the highest final score associated with that NPI in the performance period will be used (81 FR 77332).
- In cases where a TIN/NPI has multiple final scores from a performance period, the hierarchy will assign: i) the APM Entity final score if there is one, ii) the highest APM Entity final score if there is more than one, and iii) if there is no APM Entity score and the clinician reports as a group and as an individual, CMS will calculate a final score for the group and individual identifier and use the highest final score for the TIN/NPI (81 FR 77332).

Changes Adopted in Final Rule. CMS adopts its proposal to modify these policies for assignment of a final score to account for the addition of virtual groups, which is finalized elsewhere in this rule. (See section II.A.4. above). The virtual score will be prioritized over other final scores, except that the APM Entity final score will be prioritized over any other score for a TIN/NPI, including one that is a virtual group.

The final hierarchies involving virtual groups are summarized in Tables 30 and 31 of the final rule, reproduced below.

TABLE 30: Hierarchy for Final Score When More than One Final Score is Associated with a TIN/NPI	
Example	Final Score Used to Determine Payment Adjustments
TIN/NPI has more than one APM Entity final score	The highest of the APM Entity final scores
TIN/NPI has an APM Entity final score and also has an individual score	APM Entity final score
TIN/NPI has an APM Entity final score that is not a virtual group score and also has a group final score	APM Entity final score

TIN/NPI has an APM Entity final score and also has a virtual group score	APM Entity final score
TIN/NPI has a virtual group score and an individual final score	Virtual group score
TIN/NPI has a group final score and an individual final score, but no APM Entity final score and is not in a virtual group	The highest of the group or individual final score

TABLE 31: No Final Score Associated with a TIN/NPI			
MIPS Eligible Clinician (NPI 1)	Performance Period Final Score	TIN/NPI Billing in MIPS Payment Year (yes/no)	Final Score Used to Determine Payment Adjustments
TIN A/NPI 1	90	Yes (NPI 1 is still billing under TIN A in the MIPS payment year)	90 (Final score for TIN A/NPI 1 from the performance period)
TIN B/NPI 1	70	No (NPI 1 has left TIN B and no longer bills under TIN B in the MIPS payment year)	n/a (no claims are billed under TIN B/NPI 1)
TIN C/NPI 1	n/a (NPI 1 was not part of TIN C during the performance period)	Yes (NPI 1 has joined TIN C and is billing under TIN C in the MIPS payment year)	90 (No final score for TIN C/NPI 1, so use the highest final score associated with NPI 1 from the performance period)

b. MIPS Payment Adjustment Factors

No changes were proposed to the policies adopted in the 2017 QPP final rule (81 FR 77332-77333) regarding the calculation of the MIPS adjustment factor.

c. Establishing the Performance Threshold

Changes in Final Rule. CMS finalizes its proposal that, for the 2020 payment year, the performance threshold will be set *at 15 points*, and this threshold is codified in the regulatory text at 42 CFR 414.1405(b)(5).

d. Additional Performance Threshold for Exceptional Performance

For determining the additional MIPS payment adjustment for exceptional performance for the 2020 MIPS payment year, CMS finalizes its proposal to continue the additional performance threshold of 70 that was adopted in the 2017 QPP final rule.

e. Other Issues

No changes were proposed to the scaling and budget neutrality requirements for the MIPS adjustment factors or to the additional MIPS adjustment factors (81 FR 77339-40).

f. Application of the MIPS Payment Adjustment Factors

The MIPS adjustment factor and, if applicable, the additional MIPS payment adjustment factor, are applied to Part B payments for items and services furnished by the MIPS eligible clinician during the year. CMS finalizes its proposal to apply the adjustment to the Medicare-paid amount for items and services furnished by the MIPS eligible clinician during the year. This is consistent with the approach used for the value-based modifier, and means that beneficiary cost sharing and coinsurance amounts will be unaffected by the application of the MIPS adjustment factors.

g. Example of MIPS Adjustment Factors

Figure A, copied below from the final rule, illustrates how scores will be converted into adjustment factors. For 2020, the performance threshold is 15 points, and the applicable percentage is 5 percent. As shown, clinicians with a final score of 15 will receive a 0 percent adjustment. The scale for other scores is not completely linear for two reasons. First, all clinicians with a final score between 0 and $\frac{1}{4}$ of the performance threshold (0 and 3.75 in the example) must receive the lowest negative adjustment of -5 percent. Second, the linear sliding scale line for the positive adjustment factor is affected by the budget neutrality scaling factor. If the budget neutrality scaling factor is greater than 0 and less than or equal to 1.0, then the adjustment factor for a final score of 100 will be less than or equal to 5 percent. If the scaling factor is above 1.0, but less than or equal to the specified limit of 3.0, then the adjustment factor for a final score of 100 will be higher than 5 percent. CMS anticipates that because the performance threshold has been set so low at 15 points, the scaling factor will be less than 1.0 and the payment adjustment for clinicians with a final score of 100 will be less than 5 percent.

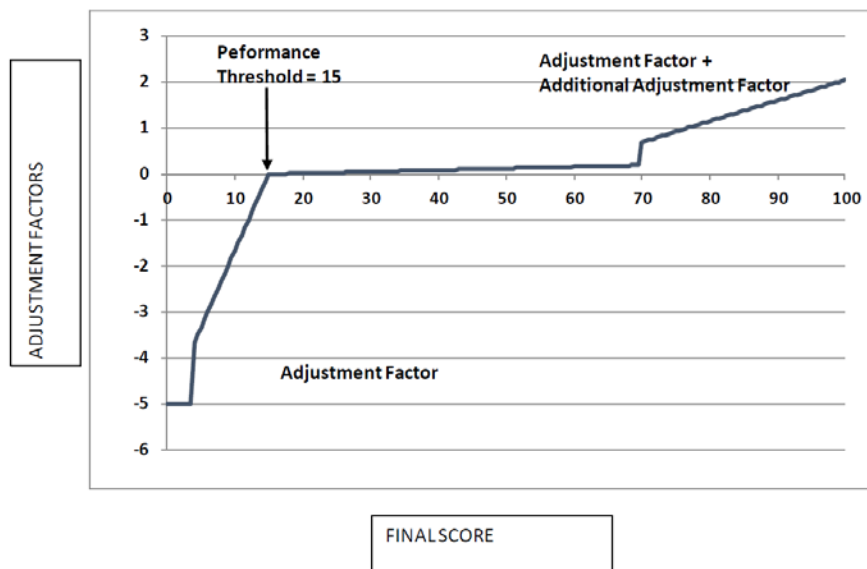
In Figure A, the illustrative budget neutrality scaling factor is 0.06; MIPS eligible clinicians with a final score of 100 would receive an adjustment factor of 0.31 percent (5.0 percent X 0.06). The additional performance threshold is 70. A score of 70 will receive an additional adjustment factor of 0.5 percent and the factor will increase to the statutory maximum of 10 percent for a perfect final score of 100, with a separate scaling factor applied to ensure distribution of the \$500 million payments. In Figure A, the illustrative scaling factor for the additional adjustment is 0.175; a clinician with a final score of 100 will receive an additional adjustment factor of 1.75 percent (10 percent X 0.175), and therefore a total adjustment of 2.05 percent (0.31 percent + 1.75 percent).

CMS notes that the actual MIPS payment adjustments will be determined by the distribution of performance scores; the greater the number of clinicians above the threshold, the more the scaling factors will decrease, and vice versa.

Table 32 in the final rule compares the point system and associated adjustment adopted for the transition year to the approach finalized for the 2020 MIPS payment year.

The final rule also includes three examples of how MIPS eligible clinicians can achieve a final score at or above the finalized 15-point performance threshold. The examples are for a clinician in a small practice with one quality measure and one improvement activity; a medium size group; and a non-patient facing clinician. CMS notes these examples have been updated from the proposed rule, where they identified a calculation error in Example 3.

FIGURE A: Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Performance Threshold and Additional Performance Threshold for the 2020 MIPS Payment Year



9. Review and Correction of Final Score

a. Performance feedback

MIPS Eligible Clinicians. CMS finalizes its proposal to provide performance feedback at least annually to MIPS-eligible clinicians and groups. Feedback will be provided on the quality and cost performance categories beginning July 1, 2018 (for the 2017 performance period), and, if feasible, also for the improvement activities and ACI categories. In addition, the measures and activities specified for the 2017 performance period for all four performance categories along with the final score will be included in performance feedback provided on or about July 1, 2018.

MIPS APM Participants. As noted above, beginning in 2018, MIPS eligible clinicians who participate in MIPS APMs will receive performance feedback if technically feasible.

Clinicians Who Are Not MIPS Eligible. Performance feedback will also be provided beginning July 1, 2018 to eligible clinicians and groups that are not MIPS eligible but voluntarily report on measures and activities under MIPS. The initial feedback will be with respect to data voluntarily reported and collected during the 2017 performance period.

Feedback Mechanisms. CMS expects to use a new and improved format for the July 1, 2018 performance feedback, which will be provided through the QPP website (qpp.cms.gov). CMS intends to leverage additional mechanisms such as IT vendors, registries and QCDRs to help disseminate information contained in the performance feedback. As previously finalized, registries and QCDRs will continue to be required to provide performance feedback via the third-party intermediary with which they are working. CMS also intends to continue to work with third party intermediaries as it explores and develops performance feedback mechanisms, such as an API, which would allow authenticated third-party intermediaries to access the data used to provide confidential feedback to eligible clinicians and groups, to the extent allowed under privacy and security rules.

Information on Other Medicare Expenditures. As required by statute, CMS finalizes its proposal that, beginning with the July 1, 2018 performance feedback, it will make available to MIPS-eligible clinicians, information about the items and services furnished to their patients by other suppliers and providers for which payment is made under Title XVIII. CMS will include as much of the following data elements as technically feasible: names of suppliers/providers; types of items and services furnished and received; dollar amount of services provided and received; and the dates that items and services were furnished.

b. Targeted Review

No changes were proposed to the targeted review process adopted in the 2017 QPP final rule. Under that process:

- An eligible clinician may request a targeted review of the MIPS adjustment factor or the additional MIPS adjustment factor during the 60-day period that begins on the day the MIPS payment adjustment is made available by CMS and ends on September 30 of the year prior to the MIPS payment year or a later date specified by CMS.
- CMS will first respond with a decision as to whether a targeted review is warranted.
- The MIPS eligible clinician or group may include additional information in support of their request when the request is submitted. If CMS requests additional information to assist in the review, the supporting information must be received within 30 calendar days of the request (modified from 10 days in the proposed rule). Non-responsiveness to the request for additional information will result in the closure of that targeted review request, although another review request may be submitted if the submission deadline has not passed.
- Decisions based on the targeted review will be final, and there will be no further review or appeal.

c. Data Validation and Auditing

Background. CMS adopted data validation policies in the 2017 QPP final rule. Under those policies, CMS will selectively audit eligible clinicians on a yearly basis. An eligible clinician or group selected for audit must:

- Provide all data as requested to CMS (or its contractor) within 45 days or an alternate time frame that is agreed to by CMS and the clinician. Data will be submitted via email, facsimile, or an electronic method via a secure website maintained by CMS.

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

Changes in the Final Rule. CMS finalizes, with a modification from the proposal rule, revisions to the regulatory text (§414.1390) to include three provisions that were addressed in the 2017 QPP final rule but not codified.

- All MIPS eligible clinicians and groups that submit data and information to CMS for purposes of MIPS will be required to certify to the best of their knowledge that the data submitted to CMS are true, accurate, and complete. The certification must accompany the submission.
- If a MIPS eligible clinician or group is found to have submitted inaccurate data for MIPS, CMS may reopen and revise a MIPS payment adjustment in accordance with the rules set forth at 42 CFR 405.980 through 405.986. The final language clarifies that the revision applies to the payment adjustment and not, as proposed, the “MIPS payment determination.”
- 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.

The proposed rule would have required a 10-year retention period; CMS reduces this to 6 years based on comments received regarding the financial and time burden associated with retaining data and information. Responding to other comments, CMS says that under previously adopted requirements, MIPS eligible clinicians and groups must provide substantive primary source documents as requested, which may include copies of claims; medical records; other sources used in data calculations for MIPS measures and activities; and verification of records for Medicare and non-Medicare beneficiaries. CMS intends to continue to provide clarification through subregulatory guidance.

<https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html>

B. Overview of the APM Incentive for Participation in Advanced APMs⁶

1. Changes to Terms, Definitions, and Regulatory Text

In addition to the MIPS track, the Quality Payment Program (QPP) includes an APM Incentive track. The APM incentive may be earned by “eligible clinicians”⁷ who become Qualifying

⁶ Since QP calculation results simultaneously allow Partial QP determinations, Partial QP processes are discussed separately only when they differ from those for QP status.

⁷ Clinicians eligible to become QPs are physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, physical or occupational therapists, qualified speech-language pathologists, and qualified audiologists. In contrast, MIPS-eligible clinicians for Performance Years 2017 and 2018 are defined as physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists.

Participants (QPs) through sufficient participation in Advanced APMs (payment years 2019 and 2020) or through their combined participation in Advanced APMs and Other Payer Advanced APMs (payment year 2021 and later).⁸ A clinician reaching QP status for a performance year is excluded from MIPS reporting for that year and from MIPS payment adjustments for the associated payment year. For payment years 2019 through 2024, each QP receives a lump sum bonus; starting in 2026, the annual Physician Fee Schedule update is higher for QPs than for non-QPs.⁹ (Partial QP status requires meeting lower thresholds of APM participation; the only associated benefit is an option not to report to MIPS.) In the 2018 QPP Proposed Rule (hereafter in this summary referred to as the proposed rule), CMS addressed QP related definitions and terms. CMS reviews related comments and outlines final actions.

QP Performance Period. CMS establishes a single performance period (January 1-August 31) for both the “Medicare Only” and “All-Payer” qualifying options.

Attributed Beneficiary. CMS proposed to apply the definition of “Attributed Beneficiary” only to Advanced APMs and not to Other Payer Advanced APMs; this allows QP status determination at the individual rather than entity level for Other Payer Advanced APM clinicians. CMS finalizes the modified definition as proposed.

Other Payer/Medicaid APM. CMS proposed to clarify that any non-Medicare payment arrangement is an “Other Payer” arrangement and that a “Medicaid APM” must meet all the criteria proposed for Other Payer Advanced APMs. CMS finalizes the clarifications as proposed.

2. Advanced APM Financial Risk Criteria and Revenue-Based Standards

An Advanced APM must require its participating entities to bear financial risk for more than “nominal” monetary losses.¹⁰ CMS previously set distinct “generally applicable” and “Medical Home Model” standards for defining both financial risk-bearing and more than nominal amounts. Nominal amount standards are either benchmark-based (total cost of care) or revenue-based. The two revenue-based standards are specified in terms of the “average estimated total Medicare Parts A and B revenue of participating APM Entities.” CMS addressed several aspects of the risk-bearing criterion and nominal amounts standards in the proposed rule and now reviews comments received and describes final decisions.

50 eligible clinician limit. Starting with the 2018 QP performance period, the Medical Home Model financial risk and nominal amount standards apply only to medical home APM entities with less than 50 eligible clinicians in the organization through which the APM Entity is owned and operated. CMS finalized an exemption from the limit entities enrolled in Round 1 of

⁸ CMS uses “Advanced APM” only when Medicare is the payer; the remaining APMs are termed “Other Payer Advanced APMs”. Sufficient participation is defined by predetermined criteria (statutory and/or regulatory) for Part B payments received or number of patients treated through Advanced APMs or Other Payer Advanced APMs.

⁹ Bonus = 5 percent of payments for Part B covered professional services during the immediately preceding year; QP update = 0.75 percent versus non-QP update of 0.25 percent.

¹⁰ Alternatively, the model may be a Medical Home Model expanded under section 1115A(c) of the Act; none have been so expanded to date. An Advanced APM also must require CEHRT use by participants and link covered professional services payments to MIPS-comparable quality measures.

the Comprehensive Primary Care Plus (CPC+) model, as the limit was finalized after those entities had executed their agreements with CMS. However, Round 2 and future CPC+ participants are not be exempt.

Revenue-based nominal amount standard clarification. The generally applicable and medical home revenue-based standards are defined in terms of “average estimated total Medicare Parts A and B revenue of participating APM Entities”. CMS proposed to clarify that the standards refer to revenues received by all providers and suppliers in participating APM entities, not just to those revenues paid directly to the entities.¹¹ CMS finalizes the clarifying amendments as proposed.

Generally applicable revenue-based nominal amount standard. CMS finalizes an extension of the current standard of 8 percent for the 2019 and 2020 QP performance periods and to address future years’ standards through subsequent rulemaking.

Medical Home Model nominal amount standard. CMS adjusts downward the progression of the medical home standard to better reflect greater financial challenges faced by risk-bearing medical home model participants compared to other APM entities (e.g., cash flow).

The progression is now:

- 2.5 percent for the 2018 QP performance period (unchanged),
- 3 percent for 2019,
- 4 percent for 2020, and
- 5 percent for 2020 and later)

3. Qualifying Participant and Partial Qualifying Participant Determination

In the proposed rule, CMS addressed two QP determination special situations: first, when advanced APM start/end dates are not synchronized with those of the QP Performance Period, and second, when an eligible clinician participates in multiple Advanced APMs during a single performance period. (As noted above, CMS has opted not to adopt new dates for the QP Performance Period, so the dates will remain January 1 through August 31 as previously finalized in 2017.) CMS now reviews comments received and describes final actions.

Asynchronous start/end dates. Advanced APM start/end dates are set by CMS and may not match those of the standard QP performance period definition. To treat the model’s entities and clinicians fairly when dates are asynchronous, CMS proposed to perform QP calculations using only data from dates during which the entity could in fact participate in active model testing. Data from models in active testing for less than 60 continuous days would not be included (except when an individual eligible clinician participates in multiple Advanced APMs,

¹¹ CMS first calculates for each APM Entity the estimated total Medicare Parts A and B revenue of all providers and suppliers at risk, then calculates an average of those revenue estimates for all entities in the model. If the average estimated total revenue at risk for all APM Entities equals or exceeds the current 8 percent standard, the APM would satisfy the generally applicable revenue-based nominal amount standard (82 FR 30173).

discussed below).¹² CMS proposed to make QP determinations for each snapshot period during a year in which a model was actively tested for 60 or more continuous days.¹³ CMS finalizes as proposed the management of QP determinations involving data from Advanced APMs with asynchronous start/end dates. Relatedly, CMS will also make QP determinations for snapshot dates that occur only after an APM meets the 60-day threshold, without regard to start/end dates.

Participation in multiple APMs. CMS will make QP determinations for a clinician participating in two or more Advanced APMs using data from the full QP Performance Period, regardless of APM start/end dates.

For the clinician participating in multiple Advanced APM entities, no one of which achieves QP status, CMS previously finalized that the clinician's data are summed and that QP calculations include data from the entire QP Performance Period irrespective of APM start/end dates. The proposed rule discusses scenarios in which a clinician participates in more than two APM entities and Advanced APMs and one entity of one APM terminates early, yet the entities of the second APM do not terminate early. CMS finalizes that such a clinician will remain eligible for QP determination under the second APM (with no terminating entities) and CMS will perform the relevant calculations.

4. All-Payer Combination Option

a. Overview

For payment years 2019 and 2020, eligible clinicians can reach QP status only via the Medicare Option, providing sufficient care through Advanced APMs to reach pre-set thresholds for Part B payments received or for beneficiaries treated as a percentage of the clinician's total Medicare practice.¹⁴ Starting with payment year 2021, a clinician alternatively can achieve QP status through the All-Payer Combination Option. All-Payer option thresholds can be met by combining payments or patients from Other Payer Advanced APMs with those from Advanced APMs. CMS will assess clinician QP status under both options and will use the result most favorable to the clinician. Thresholds and determination decision trees for both options were published previously (81 FR 77460-77461) and are reproduced in the final rule as Tables 36-37 and Figures 1-2.¹⁵

¹² An Advanced APM is in active testing if APM entities are furnishing services that will count toward APM entity performance under the model and starts once any entity begins furnishing such services. If an entity could participate in the model but chooses to delay beginning participation or to terminate early, QP calculations would use data from the entire performance period

¹³ The snapshot periods each start annually on January 1 and end March 31, June 30, or August 31, respectively.

¹⁴ Part B payment thresholds are set in statute while patient count thresholds are set by the Secretary.

¹⁵ For example, for payment years 2021-2022, the All-Payer Option QP payment threshold is 50 percent, split into 25 percent Medicare and 25 percent Other Payer; the patient count threshold is 35 percent, split into 20 percent Medicare and 15 percent Other Payer.

b. Other Payer Advanced APM Criteria

(1) General Considerations

CMS notes that Medicare Health Plans¹⁶ are considered Other Payers, as is any payer, public or private, other than fee-for-service Medicare. CMS recalls that each Other Payer Advanced APM must meet criteria for CEHRT use, clinician payment based on MIPS-comparable quality measures, and bearing more than nominal financial risk, to achieve Other Payer Advanced APM designation. (§414.1420)

(2) Other Payer Medical Home Model Definition

CMS previously defined Medical Home Model and Medicaid Medical Home Model at. In the proposed rule, CMS sought comment on a definition of Other Payer Medical Home Model. CMS opts not to establish a definition of Other Payer Medical Home Model but welcomes further comments. (Although a Medicaid Medical Home Model is an Other Payer Advanced APM Model, the former has a unique definition and is not affected by the decision not to define the latter.)

(3) Other Payer Advanced APM Financial Risk Criteria

Risk Components. CMS previously defined the Other Payer Advanced APM Generally Applicable Nominal Amount Standard as having three components:

- marginal risk at least 30 percent;
- minimum loss rate no more than 4 percent;
- and total risk for which the APM entity is responsible set as at least 3 percent of expected expenditures.

This standard differs from the Advanced APM nominal risk standard of either 3 percent of expected expenditures for which the APM Entity is responsible (benchmark-based) or 8 percent of average estimated Parts A and B revenues (revenue-based). CMS believes that the tripartite Other Payer standard assures that Other Payer Advanced APM payment arrangement risks, in which CMS has no direct design role, are similarly rigorous to those of Advanced APMs, for which CMS controls the design.

CMS finalizes no changes, however, believing the additional components help to ensure significant risk adoption by Other Payer Advanced APMs.

Revenue-based Standard. CMS adds a revenue-based generally applicable nominal amount standard for the 2019 and 2020 QP performance periods but only for those Other Payer Advanced APMs whose payment arrangements expressly define risk in terms of revenue. The new standard parallels that for Advanced APMs and is met when the model requires an APM Entity to owe or potentially forego 8 percent or more of total combined revenues from the payer

¹⁶ Medicare Health Plans include Medicare Advantage, Medicare-Medicaid Plans, section 1876 Cost Contract Plans, section 1833 Health Care Prepayment Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) Plans.

of the entity's participating providers and suppliers. It also finalizes that the standard applies only to APMs whose payment arrangements explicitly define risk in terms of revenue.

Applicable Standards. CMS proposed that each Other Payer Advanced APM must satisfy either the revenue-based or the tripartite standard and finalizes this proposal. CMS does not establish a special small or rural Other Payer Advanced APM nominal risk amount standard.

Medicaid Medical Home Model risk progression. CMS reduces the rate of progression of the nominal risk standard amount for Medicaid Medical Home models for the:

- 2019 QP Performance period from 4 percent to 3 percent of the APM Entity's total revenue under the payer,
- for the 2020 period from 5 percent to 4 percent

The risk would remain at 5 percent for the 2021 period and beyond. CMS also clarifies that total revenues from all providers or entities under the Other Payer Advanced APM arrangement will be used in risk standard calculations.

c. Other Payer Advanced APM Determination Process

In the proposed rule, CMS outlined parallel processes, Payer Initiated and Eligible Clinician Initiated, for determining whether payment arrangements meet Other Payer Advanced APM criteria. While the two proposed processes had similar elements, their timelines were distinct and some elements varied by payer type.¹⁷ The final rule addresses general and payer-specific considerations for each process type, describing comments received and final actions taken by CMS.

(1) Payer Initiated Other Payer Advanced APM Determination Process

After comment review, CMS finalizes the following features of the Payer Initiated Process:

- The process is voluntary and generally involves the same steps for all payer types for each QP Performance Period.
- Other Payer Advanced APM determinations will be effective for one year at a time.
- For payment arrangements under Title XIX, Medicare Health Plans, and CMS Multi-Payer Models, payers may request determinations in 2018, starting prior to the 2019 QP performance period, and annually thereafter. The QP Performance Period will be January 1- August 31 of each year.
 - These payers also may concurrently request determinations for their commercial arrangements that follow the same payment arrangements as their Title XIX or CMS Multi-Payer arrangements, but not their Medicare Health Plans.
- Remaining other payers (e.g., commercial, other private), may request determinations for their payment arrangements in 2019, prior to the 2020 All-Payer performance period, and annually thereafter.

¹⁷ The processes were depicted in Tables 50-54 of the proposed rule (82 FR 30188 through 30194).

Guidance and Submission Form. After comment review, CMS finalizes the following general workflow elements for the Payer Initiated process:

- Providing Payer Initiated process guidance for each payer type before the first submission period occurs in 2018;
- Making available a standard Payer Initiated Submission Form before the first submission period;
 - Use of the form is mandatory and a separate form is required for each other payer arrangement, as determinations are made individually. A multi-track payment arrangement may be submitted as a single request with specific information for all tracks; individual track determinations will be made.
 - The form's questions will include some applicable to all arrangements and some specific for various arrangement types.
 - The form will allow payers to attach required supporting documentation.
- Varying submission period opening and end dates by payer type to align with operational timelines of existing CMS processes to enhance efficiency;
- Notifying a payer when a form contains incomplete or inadequate information and allowing 15 business days for the payer to respond;
- Not rendering a determination for an arrangement with insufficient information;
- Notifying payers of determinations as soon as feasible after the relevant submission deadline;
 - Determinations are final and not subject to reconsideration or review.
- Posting an Other Payer Advanced APM List on the CMS Website.
 - Determinations made through the Payer Initiated Process (plus those for Title XIX requested through the Eligible Clinician Initiated process) will be posted before the associated QP Performance Period starts.
 - The list will be updated with other Eligible Clinician Initiated determination results after the associated QP Performance Period ends.

(2) APM Entity or Eligible Clinician Initiated Other Payer Advanced APM Determination Process

CMS finalizes the following features of the Eligible Clinician Initiated Process:

- Both eligible clinicians and APM Entities may submit determination requests through the process; requests from either source will be handled identically. Requests from either source are not necessary for Other Payer arrangements already determined to be Other Payer Advanced APMs through the Payer Initiated Process.
- The process is voluntary and generally involves the same steps for all payer types for each QP Performance Period.
- Other Payer Advanced APM determinations will be effective for one year at a time.
- For payment arrangements under Title XIX, eligible clinicians may request determinations in 2018, starting prior to the 2019 QP Performance Period, and annually thereafter. The QP Performance Period will be January 1- August 31 of each year.
- For all other payer arrangements, eligible clinicians may request determinations in 2019, prior to the 2020 All-Payer performance period, and annually thereafter.

CMS finalizes the following general workflow elements for the Eligible Clinician Initiated process; differences from the Payer Initiated process are *italicized*:

- Providing *Eligible Clinician Initiated process guidance* for each payer type before the first submission period occurs in 2018;
- Making available a *standard Eligible Clinician Initiated Submission Form* before the first Submission Period;
 - Use of the form is mandatory and a separate form is required for each Other Payer arrangement. A multi-track payment arrangement may be submitted as a single request with relevant information for all tracks.
 - The form's questions will include some applicable to all arrangements and some specific for various arrangement types.
 - The form will allow *requestors (APM Entity or Eligible Clinician)* to attach required supporting documentation.
- *The submission period begins on August 1 and ends on December 1 of the associated QP Performance Period year (except for Title XIX arrangement requests;*
- Notifying the *requestor* when a form contains incomplete or inadequate information and allowing 15 business days for the *requestor* to respond;
- Not rendering a determination for an arrangement with insufficient information;
- Notifying *requestors* of determinations as soon as feasible after the submission deadline;
 - Determinations are final and not subject to reconsideration or review.
- Posting an Other Payer Advanced APM List on the CMS Website;
 - Determinations made through the Payer Initiated process (plus those for Title XIX requested through the Eligible Clinician Initiated process) will be posted before the associated All-Payer QP Performance Period starts.
 - The list will be updated with other Eligible Clinician Initiated determination results after the associated All-Payer QP Performance Period ends.

(3) Medicaid APMs and Medicaid Medical Home Models

After reviewing comments, CMS finalizes the following:

- To assess at the county level whether and where a state¹⁸ operates a Medicaid APM(s) or Medicaid Medical Home(s) that meets Other Payer Advanced APM criteria;
- To identify counties or specialties excluded from participating in the Medicaid Other Payer Advanced APM (using answers by states on APM determination request forms);
- To make the Other Payer Advanced APM determinations at the request of state, APM entities, or eligible clinicians, doing so prior to the All-Payer performance period;¹⁹ and
- To exclude all Medicaid payments and patients from the numerator and denominator of QP calculations for an eligible clinician when a Medicaid Other Payer Advanced APM is not available for participation by that clinician due to county or specialty APM restrictions (using the county and specialty as provided by the clinician).

¹⁸ "States" in this context include the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

¹⁹ If CMS receives no APM determination requests from a state for a year via states, APM entities, or eligible clinicians, CMS will assume that no Medicaid Other Payer Advanced APMs are operating in the state that year.

CMS also finalizes that states will serve in the payer role for the Payer Initiated Title XIX process and that CMS will accept determination requests through this process only from states. The submission period will run from January 1 through April 1 of the calendar year preceding the relevant QP Performance Period. APM entities and eligible clinicians may request clinician-initiated Title XIX payment arrangement determinations during a special submission period (September 1 through November 1 of the calendar year preceding the relevant All-Payer performance period). States can request determinations for both Medicaid fee-for-service and Medicaid managed care plan payment arrangements. On their request submission forms, states may refer to information they have already provided to CMS, to reduce burden.²⁰ States will have 15 business days to respond to CMS notifications about incomplete information submission.

Table 38 in the rule displays the final timelines for both the Payer Initiated and Eligible Clinician Initiated Other Payer Advanced APM Determination Processes for payment arrangements authorized under Title XIX.

(4) CMS Multi-Payer Models

CMS proposed to define a Multi-Payer Model as an Advanced APM that includes at least one Other Payer arrangement designed to align with that of the parent CMS APM (e.g., CPC+ model, Oncology Care Model two-sided risk track). CMS also made proposals for conducting Other Payer Advanced APM determinations of payment arrangements whose entities are aligned with the Multi-Payer models.

Streamlined Process. Comments included requests for a streamlined process for the aligned payers seeking Other Payer Advanced APM determinations. CMS agrees to utilize aligned payers' previously submitted information and to communicate with those payers about remaining information needed for Other Payer Advanced APM determination. CMS disagrees that automatic consideration of aligned payer arrangements is appropriate and declines the request.

Having received no other comments, CMS finalizes the proposed Multi-Payer Model definition along with the following related to Other Payer Advanced APM determinations of arrangements in which CMS Multi-Payer Model aligned payers are participants:

- Aligned payers may request Payer Initiated Other Payer Advanced APM determinations from January 1 through June 1 of the year before the QP Performance Period (June 30 was proposed inadvertently and that error is now corrected). Each aligned payer's arrangements are assessed independently.
- When a Multi-Payer model agreement includes a state specifying uniform payment arrangements across state-based payers (e.g., Vermont all-payer model), the state will serve in the payer role (i.e., initiate the request on behalf of all payers and provide required information for all payers to CMS).

²⁰ Information could include State Plan Amendment or 1115 demonstration waiver application, Special Terms and Conditions document, implementation protocol document, or other document describing the 1115 demonstration arrangements.

- When Medicaid or a Medicare Health Plan is the aligned payer, the Other Payer Advanced APM determination must follow the Medicaid or Medicare Health Care Plan process and timeline, respectively.
- APM entities and eligible clinicians also may request aligned Other Payer determinations from August 1 through December 1 of the associated QP Performance Period using the Eligible Clinician Initiated process.

Table 39 in the rule displays the final timelines for Other Payer Advanced APM determinations for payers aligned with CMS Multi-Payer Models.

(5) Medicare Health Plans

CMS believes that by statute only Medicare Part B payments and patients may be used in Medicare Option QP threshold calculations. As a result, eligible clinician participants in Medicare Health Plans cannot receive credit for their participation in such plans until the All-Payer Option becomes available in performance year 2019 (payment year 2021).

After comment review, CMS finalizes the following regarding Other Payer Advanced APM determinations for Medicare Health Plan payment arrangements:

- Determinations may be requested by a Medicare Health Plan using the Payer Initiated process.
 - The annual submission period will occur in the year prior to the QP Performance Period, contemporaneous with the Medicare Advantage bidding cycle. The period will open when bid packages are sent out in April and end with the bid submission deadline on the first Monday in June.²¹
- APM entities and eligible clinicians may request Other Payer Advanced APM determinations for Medicare Health Plans using the Eligible Clinician process.
 - The submission period will be August 1 - December 1 of the associated QP Performance Period.

Table 40 in the rule displays the final timelines for both the Payer Initiated and Eligible Clinician Initiated Other Payer Advanced APM Determination Processes for payment arrangements involving Medicare Health Plans.

(6) Remaining Other Payers

CMS outlined several proposals about making Other Payer Advanced APM determinations for payment arrangements involving all remaining payers (e.g., commercial, other private, and not already addressed), and reviews comments received. CMS also notes its intent to discuss this topic further in future rulemaking.

After comment review, CMS finalizes the following regarding Other Payer Advanced APM determinations for Remaining Other Payers payment arrangements:

²¹ Submission guidance will be distributed to plans near the time of the Part C and D Advance Notice and Draft Call Letter. The Payer Initiated form will be made available to plans through the CMS Health Plan Management System (HPMS).

- Determinations may be requested by a Remaining Other Payer using the Payer Initiated process.
 - The annual submission period will be detailed in future rulemaking.
- APM entities and eligible clinicians may request determinations using the Eligible Clinician process.
 - The submission period will be August 1 - December 1 of the associated QP Performance Period.

Table 41 in the rule displays the final timeline for the Eligible Clinician Initiated Other Payer Advanced APM Determination Process for payment arrangements involving Remaining Other Payers.

Table 42, also included in the rule, presents final timelines for both the Payer Initiated and Eligible Clinician Initiated Other Payer Advanced APM Determination Processes for payment arrangements involving all payer types. A typographical error from the proposed rule timeline table (82 FR 30193) is corrected by CMS in Table 42 of the final rule to properly show that that guidance will be made available to eligible clinicians, and submission will open, for payments authorized under Title XIX in September 2018, not June 2018.

Tables 38-42, outlining the processes as finalized, are combined and reproduced at the end of Section D in this summary.

d. Calculation of All-Payer Combination Option Threshold Scores and QP Determinations

For payment years 2019 and 2020, an eligible clinician may become a QP only through participation in Advanced APMs (Medicare Option). For payment years 2021 and beyond, QP status may also be reached based upon combined Advanced APM and Other Payer Advanced APM participation (All-Payer Combination Option). For each clinician, CMS will assess QP status first under the Medicare Option (by both payment and patient count methods) and then under the All-Payer Option (by both methods). CMS will apply the most advantageous of the calculation results for each clinician. CMS has ready access to the necessary payment and patient data for Medicare Option QP calculations but must rely on outside sources for All-Payer Option information.

(1) All-Payer and Medicare QP Performance Periods and QP Determination Timelines

In 2017, CMS defined a QP Performance Period, running annually from January 1 through August 31 two years prior to each payment year and planned to use data from this interval for QP assessments. For both the All-Payer and Medicare QP determinations, A single performance period of January 1 through August 31 (and three snapshot periods)²² will apply to both options.²³ CMS will provide QP determination results as rapidly as practicable.

²² January 1-March 31, January 1-June 30, and January 1-August 31.

²³ The associated terms Medicare QP Performance Period and All-Payer QP Performance Period also will not be created as proposed.

(2) QP Determination Level

CMS finalizes a proposal that allows an eligible clinician to request a QP determination at the individual level and an APM Entity to request their determination at the entity level. Should an individual request a determination and the individual's entity also request a determination, CMS will make determinations at both levels, allowing the most advantageous result to be used by the clinician.

CMS also finalizes that eligible clinicians for whom QP status is assessed individually under the Medicare Option also will be assessed only individually under the All Payer Combination Option. Such clinicians are those in Advanced APMs in which QP determinations are guided by an Affiliated Practitioner List (rather than a Participation List), plus those participating in multiple Advanced APMs entities when no single entity achieves QP status through group-level assessment.

(3) Medicare Data for Use in All-Payer Combination Option QP Calculations

CMS finalizes its proposals with modifications to reflect the decision to allow both individual and entity-based QP determinations under the All-Payer option. The finalized modification provides that:

- When making QP determinations at the individual level, CMS will use the individual eligible clinician level payment amounts and patient counts for the embedded Medicare calculations in QP determinations under the All-Payer Combination Option.
- When making QP determinations at the entity level, CMS will use APM Entity level payment amounts and patient counts for the embedded Medicare calculations in QP determinations under the All-Payer Combination Option.
- When clinicians are assessed at the individual level under the Medicare Option, they also will be assessed only at the individual clinician level under the All-Payer Combination Option.

Weighting Methodology. CMS observes that a clinician's QP threshold score calculated at the individual level could vary from the same score calculated at the entity level, disadvantaging those clinicians whose individual scores are equal to or less than their entity scores. CMS proposed to give credit to such clinicians for their participation that contributed to the higher score earned by the APM Entity through a weighting methodology. The methodology would ensure that the Medicare portion of a clinician's All-Payer Option QP score would not be less than the Medicare Option QP score received by that clinician when calculated at the entity level. The methodology multiplier formula is shown below. Thus, CMS proposed to calculate a clinician's (Medicare portion) QP threshold score twice, once individually and once with the weighted methodology; the most advantageous result would be used in the clinician's All-Payer QP determination.

$$\frac{(\text{APM Entity Medicare Threshold Score} \times \text{Clinician Medicare Payments or Patients}) + (\text{Individual Other Payer Advanced APM Payments or Patients})}{\text{Individual Payments or Patients (All Payers except those excluded)}}$$

Individual Payments or Patients (All Payers except those excluded)

CMS finalizes the policy with a modification for the finalized flexible All-Payer Option QP determination: the weighting methodology will be used only when QP determinations are made at the individual level and the individual QP Medicare Option threshold score is lower than the corresponding APM Entity group's Medicare Option score.

(4) Title XIX Excluded Patients and Payments

By statute, Title XIX payments and patients are excluded from All-Payer Combination Option QP calculations in states having no Medicaid Medical Home or Medicaid APM meeting Other Payer Advanced APM criteria. CMS proposed to implement this exclusion by:

- Determining by county whether each state has such a Medicaid medical home or APM;
- When such a Medicaid medical home or APM model is available in some but not all of a state's counties, determining medical home model availability by comparing those counties with the one in which the majority of an individual clinician's practice occurs (county as identified and certified by the clinician); and
- When such a Medicaid medical home or APM model is available to some but not all clinical specialties, determining medical home model availability by comparing those specialties with the one practiced by the individual clinician (using the clinician's CMS specialty code).

Title XIX payment and patient data would be excluded from All-Payer Combination calculations for clinicians from states determined not to have an applicable, available, Medicaid medical home or APM.²⁴ CMS finalizes the Title IX exclusion provisions as proposed.

(5) Information Submission for All-Payer Combination Option QP Determinations

Submitting Required Information. CMS clarifies that clinicians must submit all necessary Other Payer payment and patient data but will not need to submit Medicare payment or patient data for use in All-Payer QP calculations. Assuming the proposed All-Payer QP performance period (January-June), CMS proposed that Other Payer data be submitted separated out for both the January 1- March 31 and January 1- June 30 time periods, to facilitate alignment with QP determination snapshot periods. Commenters indicated confusion about timelines for Other Payer Advanced APM determinations versus All-Payer Option QP determinations and whether the snapshot dates need to include the September - December interval. CMS believes that the timelines are clearly separated and that a fourth snapshot interval is not feasible operationally. CMS goes on to finalize their proposals with modification to add a reference to the third snapshot period (January - August). CMS notes, however, that it will conduct QP determinations for the first two snapshot intervals even when no data are submitted for the third interval prior to the data submission deadline.

CMS finalizes a modified data submission policy: individual level patient and payment information must be submitted for QP determinations requested by clinicians, and entity level

²⁴ CMS has previously noted that the presence in a state of a Medicare-Medicaid Plan operating under the Financial Alignment Initiative for Medicare-Medicaid Enrollees will not be considered in the process to implement the Title XIX payment exclusion as payments under such plans cannot be clearly attributed to Medicare versus Medicaid.

patient and payment information must be submitted for QP determinations requested by APM Entities.

CMS also proposed to allow APM entities to submit individual level data on behalf of their individual clinicians. CMS further proposed that if an APM Entity or eligible clinician submits information sufficient only for the payment or the patient count method calculation, CMS will make a QP determination using the method for which sufficient data were provided. APM entities or eligible clinicians may submit data about payments, patient counts, or both. Finally, CMS proposed to create a standard form for QP data submission by APM entities or eligible clinicians; use of the form would be mandatory. Commenters were mostly supportive and asked for early release of the required data submission form with clear instructions. CMS plans to create the form under the Paperwork Reduction Act approval process (thus open to public comment) and to distribute the form with subregulatory guidance. CMS finalizes all the proposals without modification.

Information Submission Deadline. CMS clarifies that September 1 is the deadline for Other Payer Advanced APM determinations while the December 1 deadline relates to QP determination data submission. CMS acknowledges the tight timelines involved in the QP determination process but defers any changes to future rulemaking. After considering comments, CMS finalizes December 1 as the QP Determination Submission Deadline.

(6) Certification and Program Integrity

CMS proposed that an eligible clinician or APM Entity submitting information with an All-Payer QP determination request must certify to the best of its knowledge that the submitted information is true, accurate, and complete. APM Entity-submitted information must be certified by an individual authorized to legally bind the APM Entity. The certification must accompany the QP determination request form. CMS finalizes the proposal as written.

CMS also reprises program integrity provisions previously finalized and newly proposed. CMS finalizes the following:

- APM Entities and eligible clinicians who submit information must maintain all information needed (e.g., contracts, records) to enable an audit of the material submitted for an All-Payer Combination Option QP determination.
- Information must be maintained for 6 years after submission or audit completion, whichever occurs later.
- Information and supporting documentation must be provided upon request to CMS.
- The requirement to retain records longer for “special needs” as determined by CMS is deleted.

(7) Release of Submitted Information

CMS notes that information submitted for purposes of QP determination under the All-Payer Option will be kept confidential to the extent permitted by federal law to avoid exposing trade secrets or other sensitive information. Materials that a submitter designates in writing as confidential will be protected for 10 years through Exemption 4 of the Freedom of Information

Act, and the submitter will be engaged by CMS in the pre-notification disclosure process for any request for release of that material.²⁵ CMS finalizes the policy for maintaining confidentiality as proposed.

From Tables 38-42. Other Payer (OP) Advanced APM (AAPM) Determination Process Timeline for Other Payer Payment Arrangements by Payer Type

Payer Type	Payer Initiated	Date	Eligible Clinician (EC) Initiated	Date
Medicaid Title IX	Guidance sent to STATES Submission Opens STATES	Jan 2018	Guidance to ECs Submission Opens ECs	Sept 2018
	Submission Closes STATES	April 2018		Nov 2018
	CMS Notifies STATES CMS Posts OP AAPM List	Sept 2018	CMS Notifies STATES & ECs CMS Post OP AAPM List	Dec 2018
CMS Multi-Payer Model (MPM)	Guidance available to PAYERS Submission Opens PAYERS	Jan 2018	Guidance available to ECs Submission Opens ECs	Aug 2019
	Submission Closes PAYERS	June 2018	Submission Closes ECs	Dec 2019
	CMS Notifies PAYERS CMS Posts OP AAPM List	Sept 2018	CMS Notifies ECs CMS Post OP AAPM List	Dec 2019
Medicare Health Plans (MHP)	Guidance sent to MHP Submission Opens MHP	April 2018	Guidance available to ECs Submission Opens ECs	Aug 2019
	Submission Closes MHP	June 2018	Submission Closes ECs	Dec 2019
	CMS Notifies MHP CMS Post OP AAPM List	Sept 2018	CMS Notifies ECs CMS Post OP AAPM List	Dec 2019
Remaining Other Payers			Guidance available to ECs Submission Opens ECs	Aug 2019
			Submission Closes ECs	Dec 2019
			CMS Notifies ECs CMS Post OP AAPM List	Dec 2019

²⁵ The submitter will not be engaged by CMS if the agency determines that the information should be withheld, or the designation of “confidential” appears obviously frivolous. The pre-disclosure notification process can be found at 45 CFR 5.42.

Payer Type	Payer Initiated	Date	Eligible Clinician (EC) Initiated	Date
September 2019	Latest time when EC can request Other Payer Advanced APM determinations and receive results notification prior to close of data submission period for QP determinations Submission period opens for QP determinations (for ECs and APM Entities)			
December 2019	Submission period closes for EC requests for Other Payer Advanced APM determinations; ECs will not receive results notification prior to close of data submission period for QP determinations Submission period closes QP determinations (for ECs and APM Entities)			

III. Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year Interim Final Rule with Comment Period

A. Interim Final Rule Policy Implementation Parameters

a. Extreme Circumstances and Triggering Events

CMS defines extreme and uncontrollable circumstances as follows:

- rare (i.e., highly unlikely to occur in a given year) events,
- entirely outside the control of the clinician and of the facility in which the clinician practices, and
- rendering the MIPS eligible clinician to be unable to collect information that the clinician would submit for a performance category or to submit information that would be used to score a performance category for an extended period of time (for example, 3 months with respect to data collection for the quality performance category).

CMS offers an example in which a tornado or fire has destroyed the only facility where a clinician practices.

To provide support to and reduce burden for affected clinicians, CMS states that these individuals should be spared the need to apply in order to obtain MIPS exemptions, terming this the “automatic” extreme and uncontrollable circumstances policy. The automatic policy requires a triggering event that affects an entire region or locale; CMS cites declarations of major disasters by the Federal Emergency Management Agency (FEMA) or public health emergencies by the Secretary as typical triggering events. CMS goes on to label Hurricanes Harvey, Irma, and Maria as triggering events.

b. Identifying Affected Clinicians

CMS will identify affected clinicians to be covered by the extreme and uncontrollable circumstances policy through the Provider Enrollment, Chain and Ownership System (PECOS). CMS will use the PECOS practice location address for this purpose. CMS will identify affected clinicians only at the individual level for application of the automatic extreme and uncontrollable circumstances policy, even though those individual clinicians may in fact

practice in a group, and will not apply the policy at a group level.²⁶ CMS finds less urgent need for a group level policy for the QPP transition year since the performance threshold (for payment adjustment) is low and because groups are only scored as groups if they submit information collectively, so that groups are unlikely to receive negative payment adjustments.

c. General Scoring Considerations under the Automatic Policy

CMS will apply the following scoring considerations under the automatic extreme and uncontrollable circumstances policy after a triggering event:

- Assume that affected clinicians do not have sufficient measures and activities available and applicable to them for the quality and improvement activities performance categories.
- Assume that affected clinicians are experiencing a significant hardship as a result of the triggering event and would qualify for a significant hardship exception for the advancing care information performance category.
- Not require affected clinicians to submit an application to CMS requesting that the performance categories be reweighted.
- Not score category (and do reweight to zero in the final score) for any or all of the quality, advancing care information, and/or improvement activities performance categories for which affected clinicians do not submit data.
- Assign a final score equal to the performance threshold to affected clinicians with fewer than two performance category scores.
- Not include the cost performance category during the transition year because the cost performance category has a zero percent weight for the 2017 performance period.

Clinicians in affected areas who submit data in one or more categories will be scored in those categories in the usual manner under MIPS. Submitted data will be scored even if these data do not represent the entire performance period.

d. Specific Considerations for the Transition Year

CMS establishes that the automatic extreme and uncontrollable circumstances policy is being triggered for the transition year by Hurricanes Harvey, Irma, and Maria, and describes the dates and effects of those storms in detail. CMS lists the regions impacted by Hurricanes Harvey, Irma, and Maria (all of Florida, Georgia, the U.S. Virgin Islands, and Puerto Rico along with selected counties in South Carolina and Texas plus selected parishes in Louisiana).²⁷ For the transition year, CMS will apply the performance category redistributions shown in Table 48 of the rule and reproduced below.

²⁶ The MIPS definition of group will apply and includes virtual groups.

²⁷ More details of covered areas can be found at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html>

**TABLE 48: Performance Category Redistribution Policies for CY 2017 MIPS
Performance Period**

Performance Category	Weighting for the 2019 MIPS Payment Year	Reweight Scenario If No Advancing Care Information Performance Category Score	Reweight Scenario If No Quality Performance Category Percent Score	Reweight Scenario If No Improvement Activities Performance Category Score
Quality	60%	85%	0%	75%
Cost	0%	0%	0%	0%
Improvement Activities	15%	15%	50%	0%
Advancing Care Information	25%	0%	50%	25%

IV. Collection of Information Requirements

Pursuant to Paperwork Reduction Act requirements, a detailed discussion is provided regarding the information collection requirements included in the final rule, with specific estimates on the burden associated with various requirements, as shown in Tables 49 through 73.

V. Regulatory Impact Analysis

Impact by Specialty and Practice Size

CMS provides two sets of analysis by specialty and practice size using different assumptions for participation of MIPS eligible clinicians. Tables 76 and 77 summarize the average CMS estimated dollar impact of the final rule on physicians by specialty, and tables 78 and 79 summarize the impact by practice size.

TABLE 76: MIPS Estimated Payment Year 2020 Impact on Paid Amount by Specialty, Standard Participation Assumptions *

Provider Type, Specialty	Number of MIPS eligible clinicians	Paid Amount (mil) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with a Positive Adjustment with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Paid Amount
Overall	604,006	\$55,444	96.8%	97.1%	74.4%	2.9%	618.2	-118.2	0.9%
Addiction Medicine	82	\$3	97.6%	97.6%	75.6%	2.4%	0.0	0.0	0.4%
Allergy/ Immunology	1,743	\$153	95.1%	95.9%	71.9%	4.1%	1.6	-0.8	0.5%
Anesthesiology	17,105	\$837	97.6%	97.2%	73.3%	2.8%	8.4	-2.6	0.7%
Anesthesiology Assistant	927	\$10	89.8%	89.8%	70.2%	10.2%	0.1	0.0	1.1%
Cardiac Electrophysiology	2,092	\$327	97.8%	98.8%	79.8%	1.2%	4.1	-0.2	1.2%
Cardiac Surgery	1,257	\$180	99.3%	99.3%	82.9%	0.7%	2.5	-0.1	1.3%
Cardiovascular Disease (Cardiology)	21,069	\$3,391	96.0%	97.2%	78.5%	2.8%	41.6	-4.9	1.1%
Certified Clinical Nurse Specialist	1,000	\$22	96.9%	96.9%	81.9%	3.1%	0.2	-0.1	0.5%
Certified Registered Nurse Anesthetist (CRNA)	21,582	\$330	98.8%	98.6%	80.2%	1.4%	4.1	-0.7	1.0%
Chiropractic	632	\$28	94.0%	94.5%	42.7%	5.5%	0.1	-0.2	-0.1%
Clinic or Group Practice	437	\$57	97.7%	97.7%	92.0%	2.3%	0.8	-0.4	0.8%

Provider Type, Specialty	Number of MIPS eligible clinicians	Paid Amount (mil) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with a Positive Adjustment with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Paid Amount
Colorectal Surgery (Proctology)	1,071	\$93	96.0%	97.1%	74.2%	2.9%	1.1	-0.2	1.0%
Critical Care (Intensivists)	2,790	\$195	96.1%	96.7%	78.5%	3.3%	2.3	-0.5	0.9%
Dermatology	9,755	\$2,300	92.4%	93.1%	66.4%	6.9%	24.8	-4.8	0.9%
Diagnostic Radiology	31,339	\$3,267	98.4%	98.3%	69.1%	1.7%	32.7	-3.6	0.9%
Emergency Medicine	36,522	\$1,756	99.4%	99.1%	60.9%	0.9%	14.5	-1.0	0.8%
Endocrinology	4,569	\$315	97.2%	97.7%	77.7%	2.3%	3.8	-0.5	1.1%
Family Medicine***	59,028	\$3,508	97.6%	97.8%	76.3%	2.2%	42.3	-6.9	1.0%
Gastroenterology	11,298	\$1,158	95.8%	97.0%	75.3%	3.0%	13.9	-1.9	1.0%
General Practice	2,155	\$202	91.0%	91.5%	62.2%	8.5%	1.6	-1.2	0.2%
General Surgery	15,105	\$1,111	97.1%	97.4%	75.5%	2.6%	12.4	-2.3	0.9%
Geriatric Medicine	1,434	\$115	96.7%	96.9%	71.6%	3.1%	1.2	-0.4	0.7%
Geriatric Psychiatry	130	\$8	93.8%	95.4%	64.6%	4.6%	0.1	0.0	0.2%
Gynecological Oncology	869	\$82	98.6%	99.1%	77.3%	0.9%	0.9	-0.1	1.0%
Hand Surgery	1,085	\$124	93.4%	93.7%	62.0%	6.3%	1.2	-0.3	0.7%
Hematology	689	\$117	99.1%	99.7%	80.6%	0.3%	1.5	0.0	1.3%
HematologyOncology	6,853	\$2,996	97.1%	97.4%	72.8%	2.6%	29.6	-3.7	0.9%
Hospice and Palliative Care	714	\$24	99.4%	99.4%	84.6%	0.6%	0.3	0.0	1.2%

Provider Type, Specialty	Number of MIPS eligible clinicians	Paid Amount (mil) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with a Positive Adjustment with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Paid Amount
Infectious Disease	4,697	\$481	94.6%	94.9%	74.2%	5.1%	5.0	-2.2	0.6%
Internal Medicine	77,460	\$6,727	96.0%	96.3%	74.4%	3.7%	76.6	-17.7	0.9%
Interventional Cardiology	2,956	\$478	96.7%	98.5%	81.7%	1.5%	6.1	-0.3	1.2%
Interventional Pain Management	1,302	\$320	89.0%	90.1%	57.1%	9.9%	2.8	-1.4	0.5%
Interventional Radiology	1,303	\$220	98.3%	98.2%	74.1%	1.8%	1.8	-0.5	0.6%
Maxillofacial Surgery	193	\$4	98.4%	98.4%	83.9%	1.6%	0.1	0.0	1.0%
Medical Oncology	2,742	\$1,012	97.7%	98.1%	74.4%	1.9%	10.3	-1.2	0.9%
Nephrology	5,801	\$997	94.9%	96.2%	74.7%	3.8%	11.4	-2.0	0.9%
Neurology	12,056	\$1,070	95.6%	96.4%	74.4%	3.6%	11.1	-3.2	0.7%
Neuropsychiatry	82	\$6	96.3%	96.3%	78.0%	3.7%	0.1	0.0	0.6%
Neurosurgery	4,016	\$489	94.8%	95.3%	69.7%	4.7%	4.9	-1.3	0.7%
Nuclear Medicine	505	\$64	97.2%	97.6%	75.4%	2.4%	0.7	-0.2	0.9%
Nurse Practitioner	58,004	\$1,320	98.4%	98.4%	84.5%	1.6%	15.8	-5.3	0.8%
Obstetrics & Gynecology	17,233	\$244	99.5%	99.6%	88.3%	0.4%	3.0	-0.4	1.1%
Ophthalmology	14,510	\$5,829	95.7%	96.2%	73.8%	3.8%	87.3	-5.3	1.4%
Optometry	4,793	\$383	95.4%	95.5%	67.3%	4.5%	4.2	-1.3	0.8%

Provider Type, Specialty	Number of MIPS eligible clinicians	Paid Amount (mil) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with a Positive Adjustment with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Paid Amount
Oral Surgery (Dentist only)	281	\$6	98.9%	98.9%	86.5%	1.1%	0.1	0.0	1.0%
Orthopedic Surgery	18,236	\$2,456	92.9%	93.8%	60.6%	6.2%	21.0	-6.7	0.6%
Osteopathic Manipulative Medicine	316	\$21	96.5%	96.8%	75.6%	3.2%	0.2	-0.1	0.6%
Otolaryngology	6,940	\$700	94.4%	94.4%	64.2%	5.6%	6.3	-2.1	0.6%
Pain Management	1,550	\$275	89.6%	90.3%	52.8%	9.7%	2.2	-1.3	0.3%
Pathology	8,207	\$757	96.8%	96.4%	60.8%	3.6%	5.6	-2.8	0.4%
Pediatric Medicine	4,303	\$42	99.8%	99.8%	89.1%	0.2%	0.5	0.0	1.1%
Peripheral Vascular Disease	61	\$8	100.0%	98.4%	88.5%	1.6%	0.1	0.0	1.2%
Physical Medicine and Rehabilitation	5,434	\$710	92.7%	93.2%	61.1%	6.8%	5.8	-3.3	0.4%
Physician Assistant	43,047	\$853	99.1%	99.0%	82.5%	1.0%	10.5	-1.9	1.0%
Physician, Sleep Medicine	284	\$19	96.5%	98.6%	74.6%	1.4%	0.2	0.0	0.9%
Plastic and Reconstructive Surgery	2,074	\$164	96.0%	96.4%	71.4%	3.6%	1.6	-0.6	0.6%
Podiatry	9,318	\$1,059	86.6%	87.7%	51.8%	12.3%	8.1	-7.2	0.1%
Preventive Medicine	225	\$10	96.4%	97.3%	81.3%	2.7%	0.1	0.0	0.9%

Provider Type, Specialty	Number of MIPS eligible clinicians	Paid Amount (mil) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with a Positive Adjustment with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Paid Amount
Psychiatry	11,325	\$463	94.4%	94.7%	70.3%	5.3%	3.6	-3.6	-0.0%
Pulmonary Disease	9,126	\$1,068	95.7%	96.6%	76.2%	3.4%	12.4	-2.5	0.9%
Radiation Oncology	3,240	\$873	98.1%	98.1%	78.6%	1.9%	8.9	-1.0	0.9%
Rheumatology	3,550	\$1,099	96.7%	97.5%	77.5%	2.5%	13.9	-1.2	1.2%
Sports Medicine	808	\$58	96.7%	97.0%	75.1%	3.0%	0.6	-0.1	0.9%
Surgical Oncology	747	\$51	98.5%	98.7%	80.7%	1.3%	0.6	-0.1	1.1%
Thoracic Surgery	1,842	\$204	98.5%	98.6%	80.8%	1.4%	2.7	-0.2	1.2%
Other	297	\$32	98.3%	99.3%	79.1%	0.7%	0.4	0.0	1.1%
Urology	8,964	\$1,505	95.6%	96.7%	72.7%	3.3%	16.8	-2.0	1.0%
Vascular Surgery	2,846	\$662	96.1%	96.7%	72.2%	3.3%	7.1	-1.6	0.8%

Notes:

*Standard scoring model assumes that a minimum of 90 percent of clinicians within each practice size category would participate in quality data submission.

**2014, 2015 and 2016 data used to estimate 2018 payment adjustments. Payments estimated using 2015 and 2016 dollars.

***Specialty descriptions as self-reported on Part B claims. Note that all categories are mutually exclusive, including General Practice and Family Practice. 'Family Medicine' is used here for physicians listed as 'Family Practice' in Part B claims.

TABLE 78: MIPS Estimated Payment Year 2020 Impact on Total Estimated Paid Amount by Practice Size, Standard Participation Assumptions *

Practice Size	Number of MIPS eligible clinicians	Paid Amount (mil) **	Percent Eligible Clinicians Engaging with Quality Reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians with a Positive Adjustment with Exceptional Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment	Aggregate Impact Positive Adjustment (mil)**	Aggregate Impact Negative Payment Adjustment (mil)**	Combined Impact of Negative and Positive Adjustments and Exceptional Performance Payment as Percent of Paid Amount
ALL PRACTICE SIZES	604,006	\$55,444	96.8%	97.1%	74.4%	2.9%	618.2	-118.2	0.9%
1-15 clinicians	116,626	\$24,219	90.0%	90.9%	61.3%	9.1%	265.5	-82.4	0.8%
16-24 clinicians	25,488	\$3,700	92.6%	93.0%	53.6%	7.0%	30.7	-10.4	0.5%
25-99 clinicians	118,786	\$9,702	97.0%	97.1%	65.8%	2.9%	92.6	-17.6	0.8%
100 or more clinicians	343,106	\$17,824	99.4%	99.5%	83.4%	0.5%	229.4	-7.8	1.2%

Practice size is the total number of TIN/NPIs in a TIN.

*Standard scoring model assumes that a minimum of 90 percent of clinicians within each practice size category would participate in quality data submission. ** 2014, 2015 and 2016 data used to estimate 2018 payment adjustments. Payments estimated using 2015 and 2016 dollars.