



Medicare Program; CY 2018 Updates to the Quality Payment Program [CMS-5522-P]

Summary of Proposed Rule

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Note: The subject numbering in this summary may not match the proposed rule.

I. Introduction and Background

On June 20, 2017 the Centers for Medicare & Medicaid Services (CMS) placed on public display a proposed 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 proposed rule is slated for publication in the June 30, 2017 issue of the *Federal Register*. If finalized,

policies in the proposed rule generally would take effect on January 1, 2018. **The 60-day comment period ends at close of business on August 21, 2017.**¹

In the proposed rule, CMS proposes some modifications to the four MIPS performance categories: Quality, Cost, Improvement Activities, and Advancing Care Information (ACI). For the QPP Year 2, the performance period will be 2018 and the payment adjustments under MIPS will be 2020. (In this summary all references to years are calendar years unless otherwise noted.) For the 2018 performance year final score, the following weights would apply for the performance categories: 60 percent for quality, 0 percent for cost, 15 percent for improvement activities and 25 percent for ACI.

With respect to APMs, CMS would maintain many of the policies it finalized for the transition year related to the standards for Advanced APM models and the requirements for MIPS eligible clinicians to be considered Qualifying APM Participants (QPs) or Partial QPs through their participation in Advanced APMs (Medicare) and Other Payer Advanced APMs.

CMS estimates that more than one-third of the nearly 1.5 million clinicians billing to Part B (572,299) would be assigned a MIPS score for 2020 because others will be ineligible for or excluded from MIPS. An estimated 585,560 clinicians would 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. (Table 85 in the proposed rule provides additional details on these exclusions, and Tables 86 and 88 show estimated exclusions from MIPS by specialty and practice size.) Based on APMs operating in 2016, CMS estimates 74,920 qualifying APM participants (and thus excluded from MIPS) with associated incentive payment amounts that range from \$590 million to \$800 million.

For 2020, CMS estimates that it would distribute about \$173 million in payment adjustments on a budget neutral basis in the second performance year. This total excludes the additional \$500 million available under MACRA for exceptional performance payments. CMS estimated that 96 percent of eligible clinicians would have a positive or neutral payment adjustment and 3.9 percent would have a negative payment adjustment. These proportions vary by specialty and practice size. CMS estimates that approximately 180,000 to 245,000 clinicians will become QPs for the 2020 payment year based on estimates of Advanced APM participation.

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

A. MIPS Program Details

1. MIPS Eligible Clinicians

a. Definition of a MIPS Eligible Clinician

MACRA outlines the general definition of a MIPS eligible clinician for the first and second years of the MIPS program and allows the Secretary flexibility to specify additional clinician types as MIPS eligible clinicians in the third and subsequent years.

¹ Specific issues that CMS requests comments on are highlighted in bold font in this summary.

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

- To define a MIPS eligible clinician as a physician, 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.

c. Small Practices

In the 2017 QPP final rule, CMS defined small practices as practices consisting of 15 or fewer clinicians and solo practitioners. CMS also noted it would not make an eligibility determination regarding the size of small practices, but small practices would attest to the size of their practice groups.

For performance periods occurring in 2018 and future years, CMS proposes it would determine the size of small practices by utilizing claims data. Specifically, CMS proposes 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 would identify small practices based on 12 months of data starting from September 1, 2016 to August 31, 2017.

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 proposes a higher standard. An individual MIPS eligible clinician, a group, or a virtual practice under its TIN 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 the 75 percent threshold is also used in the definition for determining a non-patient facing MIPS eligible clinician.

e. Non-Patient Facing MIPS Eligible Clinicians

To account for the formation of virtual groups in the 2018 performance year, CMS proposes a modification of non-patient facing MIPS eligible clinicians. For the 2018 performance period and future years, CMS proposes to modify 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 2017, CMS published the list of patient-facing encounter codes on the QPP web site. It intends to publish the list of patient-facing encounter codes for the 2018 performance period by the end of 2017 at <https://qpp.cms.gov/about/resource-library>.

In the 2017 QPP final rule, CMS established a non-patient facing determination period for identifying non-patient facing MIPS eligible clinicians in advance of the performance period using historical data. The non-patient facing determination period is 24 months and includes:

- An initial 12-month segment which spans the last 4 months of the 2 years prior to the performance period followed by the first 8 months of the next year and include a 60-day claims run out. This time frame allows CMS to inform MIPS eligible clinicians and groups about their non-patient facing status in December prior to the start of the performance period.
- A second 12-month segment of the non-patient facing determination period which spans from the last 4 months of 1 year prior to the performance period followed by the first 8 months of the performance period in the year and include a 60-day claims run out. This time frame allows CMS to inform additional eligible clinicians and groups of their non-patient status during the performance period.

CMS states it 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 the 2018 performance period and future years, CMS proposes a modification to the non-patient facing determination period to include a 30-day instead of a 60-day claims run out for both of the 12-month segments in 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. As for the 2017 performance period, 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.

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. Specifically, the MIPS payment adjustment is applied to the amount otherwise paid under Part B for the items and services furnished by a MIPS eligible clinician during a year, beginning with 2019. 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 under section 1834(g)(2)(B) of the Act.

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. 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.

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

Section 1848(q)(6)(E) of the Act provides that the MIPS payment adjustment is applied to the amount otherwise paid under Part B for items and services furnished by a MIPS eligible clinician

during a year. 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 these items and services 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 proposes 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. 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 would be used to determine their MIPS payment adjustment.

i. MIPS Eligible Clinician Identifier

In the 2017 QPP final rule, CMS established the use of identifiers that allow MIPS eligible clinicians to be measured as an individual or through a group's performance and that the same identifier is used across all four performance categories. CMS also established the use of a single identifier, TIN/NPI, for applying the MIPS payment adjustment, regardless of how the MIPS eligible clinician is assessed.

Individual Identifiers. CMS defines a MIPS eligible clinician to mean the use of a combination of unique billing TIN and NPI combination as the identifier to assess performance of an individual MIPS eligible clinician. Each unique TIN/NPI combination is considered a different eligible clinician, and MIPS performance is assessed separately for each TIN under which an individual bills.

Group Identifiers for Performance. CMS defines a group as a single TIN with two or more eligible clinicians (including at least one MIPS eligible clinician), as identified by their individual NPI, who have reassigned their billing rights to the TIN.

APM Entity Group Identifier for Performance. CMS established that each eligible clinician who is a participant of an APM Entity will be identified by a unique APM participant identifier that is a combination of four identifiers: (1) APM Identifier (established by CMS); (2) APM Entity Identifier (established under the APM by CMS; (3) TIN(s); and (4) the MIPS eligible clinician's NPI. CMS defines an APM Entity group as an APM Entity identified by a unique APM Participant identifier.

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. Low-Volume Threshold

Beginning with the 2018 performance period, CMS proposes to increase the low-volume threshold. Specifically, CMS proposes to define an individual MIPS eligible clinicians or groups 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 (increased from \$30,000) or provides care for 200 or fewer Part B-enrolled Medicare beneficiaries (increased from 100). CMS estimates this proposal would reduce the percent of Medicare payments captured under MIPS from 72.2 percent of Medicare payments under the 2017 QPP policy to 65 percent of Medicare payments.

For the 2018 performance period and future years, CMS proposes a modification to the non-patient facing determination period to include a 30-day instead of a 60-day claims run out for both of the 12-month segments in the non-patient facing determination period.

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. As for the 2017 performance period, CMS states it 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.

CMS also discusses options for establishing a low-volume threshold based on items and services provided to a Part-B enrolled individuals by a MIPS eligible clinician.

3. Group Reporting

In the 2017 QPP final rule, CMS finalized that a group must meet the definition of a group at all times during the performance period and in order to have their performance assessed as a group:

- Eligible clinicians and MIPS eligible clinicians within a group must aggregate their performance data across the TIN, and
- A group that elects to have its performance assessed as a group will be assessed as a group across all four MIPS performance categories.

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.

In the 2017 QPP final rule, CMS discussed the establishment of a voluntary registration process, if technically feasible, for groups that intend to submit performance data via a qualified registry, EHR, or Qualified Clinical Data Registry (QCDR). CMS has determined that this is not technically feasible and is not implementing a voluntary registration process.

CMS acknowledges that groups, including multi-specialty groups, have requested an option that would allow a portion of a group to report as a separate subgroup on measures and activities that are more applicable to the subgroup and be assessed based only on the performance of the subgroup. CMS states it intends to explore the establishment of group-related policies that would permit participation in MIPS at a subgroup level and create a new identifier.

4. Virtual Groups

MACRA established the use of voluntary virtual groups for MIPS. The statute requires the establishment and implementation of a process that allows an individual MIPS eligible clinician or a group consisting of not more than 10 MIPS eligible clinicians to elect to form a virtual group with at least one other individual MIPS eligible clinician or group of not more than 10 MIPS eligible clinicians for a performance period of a year. Individual MIPS eligible clinicians and groups forming virtual groups are required to make the election as a virtual group prior to the start of the applicable performance period under the MIPS, and they cannot change their election during the performance year. MIPS eligible clinicians electing to be a virtual group must: (1) have their performance assessed for the quality and cost performance categories by a method that combines performance of all the MIPS eligible clinicians in the virtual group for the applicable performance period; and (2) be scored for the quality and cost performance categories based on such assessment. The virtual group may be based on appropriate classification of providers, such as geographic areas or by provider specialties defined by nationally recognized specialty boards of certification or equivalent certification boards.

a. Definition of a Virtual Group

CMS proposes to define a virtual group as a combination of two or more TINs composed of a solo practitioner (an individual MIPS eligible clinician² who bills under a TIN with no other NPIs billing under such TIN), or a group³ with 10 or fewer eligible clinicians under the TIN that elects to form a virtual group with at least one other solo practitioner or group for a performance

² CMS proposes to define an individual MIPS eligible clinician as a solo practitioner which, for purposes of section 1848(q)(5)(I) of the Act, is defined as a MIPS eligible clinician (as defined at §414.1305) who bills under a TIN with no other NPIs billing under such TIN.

³ CMS interprets the reference to a group “consisting of not more than 10” MIPS eligible clinicians in section 1848(q)(5)(I)(ii) of the Act to mean that a group with 10 or fewer eligible clinicians (as defined at §414.1305) would be eligible to form a virtual group.

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:

- 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 proposes to 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 below in section II.A.6.g); and
- The portion of the virtual group that achieves QP or Partial QP status may be exempt from MIPS.

CMS notes that the statute does not limit the number of TINs that may form a virtual group and it is not proposing any limit at this time. CMS is concerned that large virtual groups (such as a virtual group that contains 10 percent of all MIPS eligible clinicians in a given specialty or subspecialty) may make it difficult to compare performance.

CMS notes that qualifications as a virtual group for the purposes of MIPS do not change the application of the physician self-referral law to a financial relationship between a physician and an entity furnishing designated health services, nor does it change the need for such a financial relationship to comply with the physician self-referral law.

b. MIPS Virtual Group Identifier for Performance

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

c. Application of MIPS Group Policies to Virtual Groups

For purposes of virtual groups, CMS proposes modification of the definition of a non-patient facing MIPS eligible clinician and to the small practice, rural and HPSA designations.

Non-patient facing. CMS proposes to modify the definition of a non-patient facing MIPS eligible clinician to include clinicians in 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. CMS proposes that a virtual group would be identified as having a small practice status if the virtual group does not have 16 or more members of a virtual group (NPIs).

Rural area and HPSA practices. CMS proposes that a virtual group with 75 percent or more of the virtual group's TINs designated as rural areas or HPSA practices would be designated as a rural area or HPSA practice at the virtual group level.

Unless otherwise specified, CMS proposes to apply previously finalized and proposed group policies to virtual groups. 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).

d. Election Process

The virtual group election process must include (1) the election to be in a virtual group must be made prior to the start of the applicable performance period and cannot be changed during the performance period and (2) an individual MIPS eligible clinician or group may elect to be in only one virtual group for a performance period, and the election applies to all MIPS eligible clinicians in the group.

CMS proposes 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 1 of the year preceding the applicable period. The election deadline to participate in MIPS as a virtual group during the 2018 performance period is December 1, 2017.

Election Process. CMS proposes 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.

Stage 1: Virtual Group Eligibility Determination

CMS proposes that solo practitioners and groups with 10 or fewer eligible clinicians interested in forming or joining a virtual group would 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 would 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 would begin on July 1 and end 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 would 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 October 20, 2017, the claims data analysis would include the months of July through September 2017. The TIN size that was determined on October 20, 2017 would be retained for the duration of the election period and the 2018 performance period.

Stage 2: Virtual Group Formation

CMS proposes the following:

(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 1 of the calendar year prior to the start of the applicable performance period. CMS anticipates this election will occur via e-mail to the QPP Service Center at MIPS_VirtualGroups@cmms.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 would 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 one time prior to the start of an applicable submission period. CMS anticipates that virtual groups will use the QPP Service Center as their designated CMS contact but it will define this further in subregulatory guidance.

CMS states it would review all submitted election information, including calculating the low volume threshold at the individual and group level, and confirm whether or not each TIN within a virtual group is eligible to participate in MIPS as part of a virtual group. CMS would 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.

CMS notes that the low-volume threshold determination for a virtual group will be consistent with how this determination is made for all MIPS participants. If an individual MIPS eligible clinician is part of a practice that is participating in MIPS at the individual level, the low-volume threshold determination is made at the individual level. If an individual MIPS eligible clinician is part of a practice that is participating in MIPS at the group level, then the low-volume threshold determination is made at the group level and applies to the entire group. Thus, solo practitioners (individual MIPS eligible clinicians) or groups with 10 or fewer eligible clinicians that are determined not to exceed the low-volume threshold at the individual or group level would not be eligible to participate in MIPS as an individual, group, or virtual group.

CMS notes that stakeholders indicated that virtual groups would need at least 6 to 12 months prior to the start of the 2018 performance period to form virtual groups, prepare IT systems, and train staff to be ready for a January 1, 2018 implementation date. To provide sufficient time to form a virtual group prior to the start of the 2018 performance period, CMS is providing virtual groups with an opportunity to make an election prior to the publication of the final rule. CMS intends to make the virtual group election process available mid-September of 2017 and will publicize the specific date via subregulatory guidance.

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 would participate in MIPS as part of the virtual group. The virtual group representative would need to contact the QPP Service Center to update the information. Virtual groups must re-register before each performance period.

In the situation of a TIN within a virtual group being acquired or merged with another TIN, or no longer operating as a TIN (for example, a group practice closes) during a performance period, the solo practitioner or group's performance data would continue to be attributed to the virtual group. The remaining members of a virtual group would continue to be part of the virtual group even if only one solo practitioner or group remains.

CMS also acknowledges that since a virtual group is a combination of TINs, it could include two separate TINs associated with a solo practitioner. CMS notes that one solo practitioner (NPI)

who is practicing under multiple TINs would be able to form a virtual group with his or her own self based on each TIN assigned to the solo practitioner.

e. Virtual Group Agreements

CMS proposes that virtual groups must execute a written formal and contractual agreement between each member of a virtual group that includes the following elements:

(i) Expressly state the only parties to the agreement are the TINs and NPIs of the virtual group. CMS notes that the agreement may not be between a virtual group and another entity such as an independent practice association (IPA) or management company that has an agreement with one or more TINs within the virtual group. Virtual groups should not use existing contracts between TINs that include third parties.

(ii) Be executed on behalf of the TINs and the NPIs by individuals who are authorized to bind the TINs and the NPIs, respectively.

(iii) Expressly require 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).

(iv) Require each TIN within a virtual group to notify all NPIs associated with the TIN regarding their participation in the MIPS as a virtual group.

(v) Set 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.

(vi) Describe 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.

(vii) Require each member of the virtual group to update its Medicare enrollment information, including the addition and deletion of NPIs billing through a TIN that is part of a virtual group, 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.

(viii) Be for a term of at least one performance period as specified in the formal written agreement.

(ix) Require completion of a close-out process upon termination or expiration of the agreement that requires the TIN (group part of the virtual group) or NPI (solo practitioner part of the virtual group) to furnish all data necessary in order for the virtual group to aggregate its data across the virtual group.

CMS states that as part of the Information Collection Request (ICR) for the virtual group election, it included an agreement template that could be used by virtual groups and will be made available via subregulatory guidance. The agreement template is not required but would serve as a model agreement that could be utilized by virtual groups.

CMS stated it wants to implement an approach that balances the need to ensure all members of a virtual group are aware of their participation in a virtual group and minimize the administration burden. **CMS invites public comment on approaches for virtual groups to ensure that members of a virtual group are aware of their participation in the virtual group.**

f. Reporting Requirements

CMS proposes the following 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 would 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 would 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 would have their performance assessed at the virtual group level across all four MIPS performance categories.
- Virtual groups would need to adhere to an election process established and required by CMS.

g. Assessment and Scoring for the MIPS Performance Categories

CMS discusses the reasons it believes virtual groups need to be assessed and scored at the virtual group level for all performance categories. It believes this will reduce reporting burden and provides for a shared responsibility among all members of the virtual group. As above, CMS proposes that virtual groups would be assessed and scored across all four MIPS performance categories at the virtual group level for a performance period of a year. CMS notes that each TIN/NPI would receive a final score based on the virtual group performance, but the payment adjustment would still be applied at the TIN/NPI level.

For participants in MIPS APMs, CMS proposes to use its authority to waive the requirement that performance category scores from virtual group reporting must be used to generate the composite score upon which the MIPS payment adjustment is based for all TIN/NPIs in the virtual group. Instead, CMS would 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 would be assessed under MIPS as part of the virtual group and under the APM scoring standard as part of an APM Entity group but would 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, would be assessed under MIPS as part of the virtual group but would be excluded from the MIPS payment adjustment because of the QP status.

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). For the improvement activities and advancing care information (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) would 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 proposes that for the MIPS payment year 2021 and future years, for the quality and performance categories, the performance period would be the full year (January 1 through December 31) that occurs 2 years prior to the applicable payment year. For the purpose of the MIPS payment year 2021, the performance period for the improvement activities and ACI performance categories would 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.

6. MIPS Category Measures and Reporting

a. Performance Category Measures and Reporting

Submission Mechanisms

In the 2017 QPP final rule, CMS finalized that individual MIPS eligible clinicians and groups must submit data on measures and activities for the quality, improvement activity, and ACI performance categories. For the cost performance category, CMS finalized calculating the cost performance using administrative claims data. In addition, for individual eligible clinicians and groups that are not MIPS eligible clinicians, such as physical therapists, that elect to report to MIPS, CMS will use administrative claims based cost measures and quality measures data, if data are available.

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 proposed 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	Attestation QCDR Qualified registry EHR
Improvement Activities	Attestation QCDR Qualified registry 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 ≥ 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	Attestation QCDR Qualified registry EHR CMS Web Interface (groups ≥ 25)
Improvement Activities	Attestation QCDR Qualified registry EHR CMS Web Interface (groups ≥ 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.

In response to comments, CMS discusses revision of §414.1325(d) for purposes of the 2018 performance period to allow individual MIPS eligible clinicians and groups to submit data on measures and activities via multiple data submissions for a single performance category. This proposal could only apply when individuals and groups have fewer than the required number of measures and activities applicable and available under one submission mechanism and could submit data on additional measures and activities via one or more additional submission mechanisms, as necessary, to receive the maximum number of points under a performance category. CMS proposes for the 2018 performance period and future years 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.

Submission Deadlines

In the 2017 QPP final rule, CMS finalized the submission deadlines for all performance categories. CMS is not proposing 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

In the 2017 QPP final rule, CMS finalized a quality performance weight of 60 percent for MIPS payment year 2019 and 50 percent for 2020. For the MIPS payment year 2020 (MIPS performance year 2018), CMS proposes reweighting the quality performance weight to 60 percent to account for CMS' proposal to weight the cost performance category at zero percent

for the second MIPS payment year (2020). The quality performance category weight will be 30 percent for MIPS payment year 2021 and future years.

(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. In this proposed rule, CMS is not proposing 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, CMS finalized the requirement to report one other high priority measure (appropriate use, patient safety, efficiency, patient experience, or care coordination measures).
 - If fewer than six measures apply, then CMS finalized the requirement to 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, 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). CMS will only make determinations as to whether a sufficient number of measures are applicable for the claims-based and registry submission mechanisms.

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. In this proposed rule, CMS is not proposing 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.

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. In this proposed rule, CMS is not proposing any changes to these performance criteria.

For the 2018 performance period and future years, CMS proposes that the survey administration period would, at a minimum span over 8 weeks and would end no later than February 28th following the applicable performance period. In addition, CMS proposes to further specify the start and end timeframes of the survey administration period through its normal communication channels.

For the 2018 performance year and future years, CMS proposes removal of two Summary Survey Measures (SSMs) from the CAHPS for MIPS Survey: "Helping You to Take Medication as Directed" and "Between Visit Communication". CMS states it proposes to remove the SSM entitled "Helping You to Take Medication as Directed" due to low reliability. The SSM entitled "Between Visit Communication" currently contains only one question and CMS notes this question could also be considered related to other SSMs. CMS notes that removing this SSM would maintain consistency with the Medicare Shared Savings Program, which utilizes the CAHPS for Accountable Care Organizations (ACOs) Survey.

Data Completeness Criteria.

In the 2017 QPP final rule, CMS finalized the following data completeness criteria for MIPS during the 2017 performance period.

- Individual MIPS eligible clinicians or groups submitting data on quality measures using QCDRs, qualified registries, or via EHR need to report on at least 50 percent of the MIPS eligible clinicians' or group's patients that meet the measure's denominator criteria, regardless of the payer for the performance period. CMS states it expects to receive quality data for both Medicare and non-Medicare patients. The submission must contain a minimum of one quality measure for at least one Medicare patient.

- Individual MIPS eligible clinicians submitting data on quality measures using Medicare Part B claims need to report on at least 50 percent of the Medicare Part B patients seen during the performance period to which the measure applies.
- Groups submitting quality measures data using the CMS Web Interface or a CMS-approved survey vendor to report the CAHPS for MIP survey must meet the data submission requirements on the sample of the Medicare Part B patients CMS provides.

CMS also finalized a data completeness threshold of 60 percent for the 2018 performance period for data submitted on quality measures using QCDRs, qualified registries, via EHR or Medicare Part B claims.

CMS proposes modifications to the previously established data completeness threshold for the 2018 performance period. CMS is concerned that accelerating the data completeness threshold quickly may jeopardize clinicians who are least experienced with MIPS quality data submission. Therefore, CMS proposes to revise the data completeness criteria for the quality performance category to provide that:

- Individual MIPS eligible clinicians or groups submitting data on quality measures using QCDRs, qualified registries, or via EHR need to report on at least 50 percent of the MIPS eligible clinicians' or group's patients that meet the measure's denominator criteria, regardless of the payer for MIPS payment year 2020. The data completeness requirement will be at least 60 percent for MIPS payment year 2021.
- Individual MIPS eligible clinicians submitting data on quality measures using Medicare Part B claims must report on at least 50 percent of the Medicare Part B patients seen during the performance period to which the measure applies for MIPS payment year 2020. The data completeness requirement will be at least 60 percent for MIPS payment year 2021.

CMS notes that as MIPS eligible clinicians gain experience with the MIPS, it would propose to steadily increase these thresholds for future years through rulemaking.

In the 2017 QPP final rule, CMS finalized its approach to include all-payer data for the QCDR, qualified registry, and EHR submission mechanism. CMS is not proposing any changes to these policies.

For the QPP Year 1, MIPS eligible clinicians who fall below the data completeness threshold receive 3 points for the specific measure that fall below the data completeness threshold. For the QPP Year 2, CMS proposes that MIPS eligible clinicians would receive 1 point for measures that fall below the data completeness threshold, with an exception for small practices of 15 or fewer who would still receive 3 points for measures that fail data completeness (see discussion below in section II.C.6.b.).

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

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

¹

Clinician Type	Submission Mechanism	Submission Criteria	Data Completeness
Individual MIPS eligible clinicians	Part B Claims	<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 (Table A) or a set of specialty-specific measures (Table B).</p>	50 percent of MIPS eligible clinician's Medicare Part B patients for the performance period.
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 (Table A) or a set of specialty-specific measures (Table B).</p>	50 percent of MIPS eligible clinician's, group's, or virtual group's patients across all payers for the performance period.
Groups or virtual 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 were less than 248, then the group would report on 100 percent of assigned beneficiaries. 	Sampling requirements for the group's or virtual group's Medicare Part B patients
Groups or virtual 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. 	Sampling requirements for the group's or virtual group's Medicare Part B patients

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

(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 is not proposing any changes to this policy.

(4) Global and Population-Based Measures

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 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 is not proposing any changes for the global and population-based measures.

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

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

- Table A⁴: New Quality Measures Proposed for Inclusion in MIPS for the 2018 Performance Period,
- Table B⁵: Proposed New and Modified MIPS Specialty Measure Sets for the 2018 Performance Period,
- Table C: Proposed MIPS Measures Removed Only from Specialty Sets for the 2018 Performance Period,
- Table D: 2018 Proposed Cross-Cutting Measures,
- Table E: Measures with Substantive Changes Proposed for MIPS Reporting in 2018,
- Table F: Proposed New Improvement Activities for the Quality Program Year 2 and Future Years, and
- Table G: Proposed Improvement Activities with Changes for the Quality Program Year 2 and Future Years.

CMS proposes 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

⁴ For previously finalized MIPS quality measures, CMS refers readers to Table A in the Appendix of the 2017 QPP final rule (81 FR 77558).

⁵ 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>.

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. **CMS seeks comments on ways to incorporate cross-cutting measures into MIPS in the future.**

(1) Topped Out Measures

CMS proposes a 3-year timeline for identifying and proposing to remove topped out measures and to consider removal of the measures from the program through 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 proposes 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 proposes to phase in this policy starting with six topped out measures (listed in Table 21 in the proposed rule). CMS also proposes 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 proposed timeline:

- Year 1: The measures are 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 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 would 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 would 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 were 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 is not proposing to include CMS Web Interface measures in the proposal for removing topped out measures.

d. Cost Performance Category

In the 2017 QPP final rule, CMS finalized the measures for the cost performance category:

- The total per capita cost measures;
- The Medicare spending per beneficiary measure (MSPB); and
- Ten episode-based measures.

CMS also finalized that all measures used under the cost performance category would be derived from Medicare administrative claims data.

(1) Weighting in the Final Score

MACRA 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.

CMS states it continues to have concerns about clinicians' understanding of the cost measures and plans to use 2018 for outreach to clinicians. In addition, CMS discusses its ongoing process to develop more episode-based measures and notes that it intends to propose in future rulemaking to adopt episode-based measures that are currently being developed.

CMS notes that beginning with the 2021 MIPS payment year it is required to assign a weight of 30 percent of the MIPS final score to the cost performance category and there will not be a transition from going to a weight of 0 percent to 30 percent.

(2) Cost Criteria

(a) Measures Proposed for the MIPS Cost Performance Category

For the 2018 MIPS performance period, CMS proposes inclusion of the total per capita cost measure and the MSPB measure; CMS proposes not to include any episode-base measures.

Total Per Capita Cost and MSPB Measure.

For the 2018 performance period and future performance periods, CMS proposes to include the total per capita cost measure and the MSPB measure as finalized for the 2017 MIPS performance period. CMS notes it will continue to evaluate cost measures on a regular basis and anticipates including a list of cost measures for a given performance period in annual rulemaking.

Episode-Based Measures.

For the 2018 MIPS performance period, CMS is proposing not to include any episode-based measures in the cost performance category.

CMS intends to continue to provide confidential performance feedback to clinicians on their performance on episode-based measures. CMS states it is unable to offer a list of the new episode-based measures because this work is ongoing. It intends to provide an initial

opportunity for clinicians to review their performance based on the new episode-based measures some time in the fall of 2017. 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.

Attribution.

CMS is not proposing 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 proposes 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 is not proposing any changes in 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.

(d) 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 is not proposing 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.

e. Improvement Activities Category

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

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

MACRA specifies that a MIPS eligible clinician or group that is certified as a patient-centered medical home (PCMH) or comparable specialty practice, as determined by the Secretary, for a specific performance period must be given the highest potential score for the improvement activity performance category for the performance period.

In the 2017 QPP final rule, CMS finalized criteria for recognition as a certified-PCMH or comparable specialty practice. CMS is proposing 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 proposes to 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.

CMS proposes new, high-weighted activities in Table F in the Appendix of this proposed 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 proposes to continue the submission policy described for performance 2017 for performance year 2018 all future years.

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 would also apply to virtual groups. CMS is not proposing 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 proposes to generally apply previously finalized and proposed group policies to

virtual groups. The APM scoring standard for MIPS APMs is discussed below in section II.A.6.g.

In the 2017 QPP final rule, CMS also finalized it will provide full credit for the improvement activity for a MIPS eligible clinician or group that has received certification or accreditation as a PCMH or comparable specialty practice from a national program or from a regional or state program, private payer or other body that administers PCMH accreditation and certifies 500 or more practices for PCMH accreditation or comparable specialty practice certification. CMS finalizes 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 proposes that 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 states that if the group is unable to meet the 50 percent threshold then the individual MIPS eligible clinician may choose to receive full credit by reporting as an individual for all performance categories.

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 also proposes 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.

(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 is not proposing 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 is not proposing any changes.

f. Advancing Care Information (ACI) Performance Category

(1) Scoring

Consistent with MACRA's requirements, 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 would 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 is not proposing 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. CMS proposes to modify this policy because there are areas of the country, where immunization registries are not available. CMS proposes modifications to the scoring of Public Health and Clinical Date Registry Reporting objective. Beginning with the 2018 performance period, CMS proposes:

- If a MIPS eligible clinician fulfills the Immunization Registry Reporting Measure, the clinician would earn 10 percentage points in the performance score.
- If a MIPS eligible clinician cannot fulfill the Immunization Registry Reporting Measure, then the clinician could earn 5 percentage points in the performance score for each public health agency or clinical data registry to which the clinician reports for the following measures up to a maximum of 10 percentage points: Syndromic Surveillance Reporting; Electronic Case Reporting; Public Health Registry Reporting; and Clinical Data Registry Reporting.

CMS notes that a MIPS eligible clinician who reports to more than one public health agency or clinical data registry may receive credit in the performance score but the MIPS eligible clinician would not earn more than a total of 10 percentage points for such reporting.

CMS proposes to also apply this revised policy for MIPS eligible clinicians who choose to report the measures specified for the Public Health Reporting Objective of the 2018 Advancing Care Information Transition Objective and Measure set. If a MIPS eligible clinician cannot fulfill the

Immunization Registry Reporting Measure, then the clinician could earn 5 percentage points in the performance score for each public health agency or clinical data registry to which the clinician reports for the following measures up to a maximum of 10 percentage points: Syndromic Surveillance Reporting and Specialized Registry Reporting.

CMS is not proposing to change the maximum performance score that a MIPS eligible clinician can earn; it remains at 90 percent.

(c) Bonus Score

In the 2017 QPP final rule, for the Public Health and Clinical Data Registry Reporting objective and the Public Health Reporting objective, CMS finalized that MIPS eligible clinicians who report to one or more public health agencies or clinical data registries beyond the Immunization Registry Reporting Measure will earn a bonus score of 5 percentage points in the ACI performance category. Based on the above proposals for meeting the Immunization Registry Reporting Measure, CMS also proposes to modify this policy for the bonus score. Beginning with the 2018 performance period, CMS proposes that 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 would not receive credit under both the performance score and bonus score for reporting to the same agency or registry.

CMS proposes for the ACI Objectives and Measures, a bonus of 5 percentage points if the MIPS eligible clinician reports “yes” for one of the following measures associated with the Public Health Reporting objective: Syndromic Surveillance Reporting; Electronic Case Reporting; Public Health Registry Reporting; and Clinical Data Registry Reporting. CMS proposes that for the 2018 ACI Objective and Measure set, a bonus of 5 percentage points if the MIPS eligible clinician reports “yes” for one of the following measures associated with the Public Health Reporting objective: Syndromic Surveillance Reporting or Specialized Registry Reporting.

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

In the 2017 QPP final rule, CMS adopted a policy to award a bonus score to MIPS eligible clinicians who used CEHRT to complete certain activities in the improvement activities performance category. If a MIPS eligible clinician attests to completing at least one of the specified improvement activities using CEHRT, the clinician is eligible for a 10 percent bonus for the ACI performance category.

Beginning with the 2018 performance period, CMS proposes expansion of this policy by identifying 11 additional activities that would be eligible for the ACI performance category bonus score if they are completed using CEHRT functionality. The activities eligible for the bonus score include those listed in Table 6 in the proposed rule. 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

In the 2017 QPP final rule, CMS established a full year performance period for the ACI performance category. For the 2017 and 2018 performance period, CMS finalized a minimum of 90 consecutive days of data. CMS encourages MIPS eligible clinicians to report data for the full performance year. CMS is maintaining this policy as finalized for the 2018 performance period.

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

(3) Certification Requirements

In the 2017 QPP final rule, for the 2017 performance period, CMS finalized that MIPS eligible clinicians could use EHR technology certified to either the 2014 or 2015 certification criteria, or a combination of the two. For the 2018 performance period, CMS finalized that MIPS eligible clinicians must use EHR technology certified to the 2015 Edition.

For the 2018 performance period, CMS proposes 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 proposes to offer a 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. CMS intends this as a one-time bonus for 2018.

CMS notes that with the addition of the 2015 Edition CEHRT bonus of 10 percentage points, MIPS eligible clinicians would be able to earn a bonus score of up to 25 percentage points in 2018, an increase from the 15 percentage point bonus score for the ACI performance category in the 2017 performance year.

(4) Scoring Methodology Considerations

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.

(5) Objectives and Measures

(a) ACI Objectives and Measures Specifications

In the 2017 QPP final rule, CMS finalizes the use of objectives and measures adapted from the Stage 3 objectives and measures finalized in the 2015 EHR Incentive Programs Final Rule (80 FR 62829 – 62871). For the 2018 performance period, CMS proposes to maintain these ACI Objectives and Measures except for the modification proposed for the measures listed below. The reader is referred to the discussion in the proposed rule for more specific details about the proposed modifications.

- View, Download, Transmit (VDT) Measure
- Patient-generated Health Data Measure

- Summary of Care Measure
- Syndromic Surveillance Reporting Measure

CMS notes that it split the Specialized Registry Reporting Measure into two separate measures, Public Health Registry and Clinical Data Registry Reporting. Beginning with the 2018 performance period, CMS proposes 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.

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 5%*	Yes/No Statement
	Electronic Case Reporting	Not Required	0 or 5%*	Yes/No Statement
	Public Health Registry Reporting	Not Required	0 or 5%*	Yes/No Statement

2018 ACI Objective	2018 ACI Measure	Required/Not Required for Base Score (50%)	Performance Scoring (up to 90%)	Reporting Requirement
	Clinical Data Registry Reporting	Not Required	0 or 5%*	Yes/No Statement
Bonus (up to 25%)				
	Report to one or more additional public health and clinical data registries beyond those 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 who cannot fulfill the Immunization Registry Reporting Measure may earn 5% for each public health agency or clinical data registry to which the clinician reports, up to a maximum of 10% under the performance score.

(b) 2017 and 2018 ACI Objectives and Measures Specifications

In the 2017 QPP final rule, CMS finalizes 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). For the 2018 performance period, CMS proposes to maintain these ACI Objectives and Measures except for the modification proposed for the measures listed below. Because CMS proposes to continue to allow the use of EHR technology certified to the 2014 Edition in the 2018 performance period, CMS also proposes to allow MIPS eligible clinicians to report the ACI Transition Objectives and Measures in 2018.

- E-Prescribing Measure
- View, Download, Transmit (VDT) Measure
- Health Information Exchange
- Medication Reconciliation

Table 9: 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

2018 ACI Transition Objective	2018 ACI Transition Measure	Required/Not Required for Base Score (50%)	Performance Scoring (up to 90%)	Reporting Requirement
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 5%	Yes/No Statement
	Specialized Registry Reporting	Not Required	0 or 5%	Yes/No Statement
Bonus (up to 15%)				
Report to one or more additional public health and clinical data registries beyond the Immunization Registry Reporting measure			5% bonus	Yes/No Statement
Report improvement activities using CEHRT			10% bonus	Yes/No Statement

* A MIPS eligible clinician who cannot fulfill the Immunization Registry Reporting Measure may earn 5% for each public health agency or clinical data registry to which the clinician reports, up to a maximum of 10% under the performance score.

(c) Exclusions

CMS proposes adding exclusions to the measures associated with the Health Information Exchange and Electronic Prescribing (e-Prescribing) objectives required for the base score. CMS acknowledges that many MIPS eligible clinicians may not achieve a base score because they seldom refer or transition patients and it believes that the implementation burden of the objective is too high for these clinicians. Similarly, CMS acknowledges that many MIPS eligible clinicians do not often write prescriptions in their practice or lack prescribing authority and could not meet the e-prescribing Measure.

Beginning with the 2017 performance period, CMS proposes to establish an exclusion for the e-Prescribing Measure. Specifically, MIPS eligible clinicians who wish to claim this exclusion would select “yes” to the exclusion and submit a null value for the measure. This change would allow the clinician to fulfill the requirement to report this measure as part of the base score. CMS notes if the MIPS eligible clinician does not claim the exclusion, they would fail the measure and not earn a base score or any score on the ACI performance category.

For the Health Information Exchange Objective, CMS proposes additional exclusions because some MIPS eligible clinicians 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 proposes 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 proposes 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.

(6) Additional Considerations

(a) 21st Century Cures 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 is not proposing substantive changes to the policy. CMS proposes using the authority in section 1838(o)(2)(D) of the Act for significant hardship exceptions under the ACI performance category to assign a zero percent weight to the ACI performance category for MIPS eligible clinicians who successfully demonstrate a significant hardship. CMS would use the same categories of significant hardship and the application process established in the 2017 QPP final rule (81 FR 77240 - 77243). CMS would 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. CMS does not propose to apply any time limitation for this exception.

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

CMS discusses the concerns it has received about the administrative and financial burden associated with adopting EHR for clinicians in small and rural practices. CMS proposes a significant hardship for the ACI category for MIPS eligible clinicians in small practices (15 or fewer clinicians and solo practitioners). CMS proposes that beginning with the 2018 performance period, the ACI performance category would be reweighted to zero percent of the MIPS final score. To qualify for this exception, MIPS eligible clinicians would submit an application to CMS by December 31 of the performance period or a later date specified by CMS. MIPS eligible clinicians would need to demonstrate that there are overwhelming barriers that prevent them from complying with the ACI requirements. CMS does not propose to 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. 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.

CMS is not proposing substantive changes in the policy. CMS would automatically reweight the ACI performance category to zero percent in the MIPS final score for the MIPS payment year. CMS does not propose to apply any time limitation for this exception.

iv. Ambulatory Surgical Center (ASC) – Based MIPS Eligible Clinicians. The 21st Century Cures Act provided that no payment adjustment may be made 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 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 proposes defining 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 Place of Service (POS) code 24, 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 proposes 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. CMS is proposing this timeline to allow notification of ASC-based status prior to the start of the performance period and to align with the hospital-based MIPS eligibility determination period. CMS expects it would provide notification through the QPP website.

CMS proposes it would automatically reweight the ACI performance category to zero percent in the MIPS final score for the MIPS payment year.

CMS proposes these ASC-based policies would apply beginning with the 2017 performance period.

v. Exceptions for MIPS Eligible Clinicians Using Decertified EHR Technology. The 21st Century Cures Act provides the Secretary shall exempt an EP from the payment adjustment with

respect to a year, subject to annual renewal, if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the CEHRT used has been decertified under ONC's Health IT Certification Program.

CMS proposes 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 were granted, CMS would assign a zero percent to the ACI performance category in the MIPS final score. The exception would be subject to annual renewal and would not be granted for more than 5 years. The exception would be available beginning with the 2018 performance period.

CMS proposes 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 notes it believes this time frame is appropriate because switching to an alternative CEHRT may take up to 2 years. CMS also proposes 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. CMS proposes the application for this exception would 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 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.

CMS proposes 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 would not typically have control of the development and maintenance of their ER systems, just like those who bill using POS 22.

(c) Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists

In the 2017 QPP final rule, CMS finalized assigning a weight of zero to this performance category if there were not sufficient measures applicable and available to NPs, PAs, CRNAs, and CNSs. CMS would assign a weight of zero only in the event that these eligible clinicians do not submit any data for any of the measures specified for this performance category. CMS noted it

would use the first MIPS performance period to evaluate the participation of these MIPS eligible clinicians in the ACI performance category to determine policies for future years. CMS states it has no additional information because the first MIPS performance year is underway, and it proposes the same policy for NPs, PAs, CRNAs, and CNSs for the 2018 performance year.

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

In the 2017 QPP final rule, CMS finalized that for groups reporting ACI performance category as a group 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 as 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.

(e) 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 proposes to change the submission deadline for the 2017 performance period to December 31, 2017, or a later date specified by CMS. This would allow clinicians to know whether their application is approved prior to the data submission deadline for the 2017 performance period, March 31, 2018. CMS plans to have the application available in mid-2017. CMS proposes 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) Overview

CMS previously established an “APM Scoring Standard” applicable to MIPS eligible clinicians participating in “MIPS APMs” whose entities are governed by law, regulation, or an agreement with CMS. To be a MIPS APM, an APM must include one or more MIPS eligible clinicians on a Participation List and base payment incentives on cost and quality measures (81 FR 77249). The APM Scoring Standard follows the same general structure of the MIPS; there are reporting and scoring differences but the performance years are the same. CMS posts a MIPS APM list

annually.⁶ The APM standard is designed to reward MIPS APM clinicians by reducing reporting burden and facilitating higher MIPS scores. Scores are based on group (APM Entity) performance. CMS proposes several modifications for performance year 2018.

(2) Assessment Dates for MIPS Eligible Clinician Inclusion in MIPS APM Entity Groups

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 proposes to add December 31 as a fourth assessment date. This last date would only be available to "full TIN" APMs, defined as APMs wherein all eligible clinicians have assigned their billing rights to a participating TIN and group participation is measured at the TIN level (e.g., Medicare Shared Savings Program). The new December date would be used only to apply the APM Scoring Standard, not to make QP determinations. The new date also ensures that the APM standard would be used when scoring an eligible clinician joining a full TIN MIPS APM late in the calendar year. Only the three current assessment dates would be used to identify the MIPS eligible clinicians participating in MIPS APMs that are not full TIN APMs.

(3) MIPS APM Performance Category Score Calculations

(a) Cost Category Waivers

CMS discusses how it used various authorities to waive the cost category weight prescribed in statute, and to specify cost measures applicable to Other MIPS APMs and the MSSP for the 2019 payment year. CMS proposes to continue cost category waiving for the 2020 payment year and beyond. CMS additionally proposes using relevant authorities to waive, for MIPS APMs and the MSSP in the 2020 payment year and thereafter, the statutory mandate to incorporate improvement scoring into cost category performance calculations.

(b) Quality Category Scoring

Web Interface Reporters. In performance year 2017, MSSP and Next Generation ACOs reported quality category data via the CMS Web Interface, and these MIPS APMs are termed "Web Interface reporters". For Web Interface reporters, any data not submitted via the interface are not included in quality category scoring. CMS proposes the modification that, starting in performance year 2018, CAHPS for ACOs survey results will be added to existing scored quality measures for Web Interface reporters. Additionally, bonus points would be available for CAHPS measure performance; MIPS APM eligible clinicians (like all MIPS clinicians) are subject to a 10 percent bonus point cap for high priority measures. The CAHPS for ACOs survey is identical to the CAHPS for MIPS survey except it has one less survey question -- Between Visit Communication.

Other MIPS APM Quality Scoring. CMS proposes to add the term "Other MIPS APM" for use in discussing the APM Scoring Standard. An Other MIPS APM is defined as a MIPS APM for

⁶ The current list includes Medicare Shared Savings Program ACOs (all tracks), Next Generation ACOs, and Medicare-Medicaid Accountable Care Organization Model (MMACO, all tracks). The list is available for download at <https://qpp.cms.gov/about/resource-library>. Most Advanced APMs are also MIPS APMs.

which Web Interface reporting is not mandatory. For performance year 2018, Other MIPS APMs include the Comprehensive ESRD Care Model (CEC), the CPC+ model, and the Oncology Care Model (OCM).

Quality Category waivers. Concerns about operational readiness led CMS to use waiver authority to reweight the quality category score to zero for performance year 2017 for Other MIPS APM Entities. Relatedly, CMS waived the statutory requirement to publish a final Other MIPS APM quality measure list for that year.

Beginning with the 2018 performance year, CMS proposes to adopt quality measures for use by Other MIPS APMs under the APM Scoring Standard and to begin data collection for quality category scoring. Given the substantial heterogeneity of measures and the collection processes used across Other MIPS APMs (and their differences from general MIPS measures), CMS proposes to apply waiver authority to establish a MIPS APM quality measure list for use under the APM Scoring Standard, distinct from the annual, general MIPS final list. The separate list would serve as a “final list”, inclusive of all measure sets available for potential use by Other MIPS APM entities; one or more measures might not be used for scoring (e.g., measure specifications are revised during the year). Proposed measure sets for the CEC, CPC+, and Oncology Care Models (Other MIPS APMs) are provided as Tables 14-16 in the proposed rule.⁷ Once a list is finalized, additional measures will not be added.

Quality Category Measure Criteria. For Other MIPS APM quality category scoring, CMS proposes criteria for measures to be included in the calculations, as follows:

- Tied to payment: performance on the measure triggers a payment adjustment or incentive payment is made to the APM entity’s group;
- Available for scoring: measure results are submitted by the submission deadline, allowing inclusion in subsequent scoring calculations;
- Meets 20-case minimum: measure failure generates a null score and removal from the numerator and denominator of the quality performance percentage; and,
- Benchmark availability: a suitable benchmark (one used in the MIPS APM to calculate payment, or for general MIPS quality scoring when measure specifications are the same) is available before the submission deadline; if not, the measure receives a null score and is removed from the numerator and denominator of the quality performance percentage

Other MIPS APM Quality Category Calculation. CMS proposes that, under the APM Scoring Standard, the minimum number of measures to be reported would equal the minimum number required under the Other MIPS APM model structure. The data must be submitted before the deadline. CMS also proposes that points would 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 would be assigned if the MIPS APM failed to submit any measures on time. (Measures failing case minimums or without available benchmarks would be removed from scoring as described above.) CMS further proposes to assign bonus points when high priority measures are reported or for CEHRT end-to-end reporting. (81 FR 77297-77299).

⁷ In section II.C.6.g.(3)(b)(ii)(a)(aa), CMS incorrectly references Table 13 as the list of measures; the table actually provides the relative performance category weights for the Other MIPS APMs for 2018 and later. The table is correctly referenced later in section II.C.6.g.(4)(a).

Additionally, when measures are pay for reporting or do not measure performance on a continuum, CMS proposes to treat those measures as lacking a benchmark.

For measure scoring under the APM Scoring Standard, CMS proposes to assign point scores based on benchmark percentile distributions that are separated by deciles. Point assignment will be graduated, spread over a continuum, and taken out to one decimal place. (See Table 11 in the proposed rule for a decile distribution example.) For each measure that can be reliably scored, CMS proposes to assign 1-10 achievement points, up to the number of measures required under the terms of the Other MIPS APM. CMS proposes to identify if any of the available measures within the Other 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 derived from benchmark decile comparisons are summed and then added to any bonus points awarded, up to the maximum. The achievement + bonus point total would then be divided by the total available achievement points. For each measure set, total available achievement points would be the number of required, reliable, available measures multiplied by ten. (A sample calculation is provided in section II.C.6.g.(3)(b)(ii)(C)(bb) of the proposed rule.) The calculation result is the Other MIPS APM entity group's quality category performance percentage. CMS notes two differences from the general MIPS scoring. First, since measures lacking reliability (e.g., case minimum issues) would be deleted from scoring, a point-floor is unnecessary for Other MIPS APMs. Second, since Other MIPS APM measures are defined by the terms of the APM and not selected by the clinicians, there would be no cap on topped out measures. CMS proposes to expand the quality category performance assessment to include improvement scoring for performance year 2018 using the formula shown below for the Quality Improvement Score. A score cannot be less than zero. (See discussion below in section II.C.7.).

$$\text{Quality Improvement Score} = \frac{\text{(Absolute Improvement/Previous Year Performance Category Score Prior to Bonus Points)}}{10}$$

CMS proposes that the Other MIPS APM entity's final total quality performance category score would be calculated as shown below. The APM's total quality performance score cannot exceed 100 percent.

$$\text{Quality Performance Category Score} = \frac{\text{(Achievement Points + Bonus Points)}}{\text{Total Available Achievement Points}} + \text{Quality Improvement Score}$$

(c) Improvement Activities Performance Category

CMS does not propose changes to existing policy. MIPS APMs would receive a minimum of one half of the total possible points in this category. CMS determines a score for each model

based upon its required improvement activities. If the assigned score is below the maximum points for the category, the APM entity groups under the model are able to report additional activities.

(d) Advancing Care Information (ACI) Category

In the 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.

Multiple changes to the ACI category scoring are proposed for the MIPS (discussed above in section II.A.6.f.). Special ACI APM Scoring Standard scenarios, addressed in II.C.6.g.(3)(d)(i) of the proposed rule, deal with MIPS APM TINs that contain clinicians who qualify for an ACI category score weight of zero percent. CMS proposes the following:

- If a TIN includes a MIPS eligible clinician who qualifies for a zero percent weight of the ACI performance category and also includes one or more MIPS eligible clinicians who do not qualify for a zero percent weighting, the TIN is required to report the group's ACI data. All MIPS eligible clinicians in the TIN would 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 would 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.

(4) Total APM Entity Score Calculation

(a) Performance Category Weighting

For all APM Entities in Other Payer APMs, CMS proposes to use waiver authority to set performance category weights as follows: Cost 0 percent, Quality 50 percent, Improvement Activities 20 percent, and ACI 30 percent (described further in Table 12 in the proposed rule). The proposed weights match those for other Web Interface reporters. Table 13 in the proposed rule presents scenarios for overall reweighting when either the quality or ACI category weights are reset to zero percent for a MIPS APM Entity (shown in Table 13, Section II.C.6.g.(4)(a) of the rule).

(b) Scoring for Bonuses, Final Methodology, and Performance Feedback

Risk factor bonus scoring for MIPS APMs generally follows that proposed for MIPS (see below, section II.A.7.b). CMS proposes to use the beneficiary weighted average Hierarchical Condition Category (HCC) risk score, attributable to all MIPS-eligible clinicians in MIPS APMs, for

determining the complex patient bonus. The individual clinician weighted averages will be averaged across the APM Entity to generate the bonus score, except for TINs requiring complete clinician participation. For TINs requiring complete clinician participation, the HCC-based bonus score will be calculated at the TIN level.⁸ CMS also proposes to consider an alternative complexity adjustment approach using dual eligible patient ratios. The overall MIPS approach proposed for calculating a Small Practice Bonus will also apply to MIPS APMs whose entities contain 15 or fewer clinicians. The proposed changes for the final score methodology for MIPs apply to MIPS APMs, except for category reweighting for extreme and uncontrollable circumstances. Finally, for the 2018 performance year, CMS proposes to provide feedback to eligible clinicians subject to the APM Scoring Standard in the quality, improvement activities, and ACI performance categories, where data are available (e.g., category not reweighted to zero percent). Relatedly, for MIPS APM clinicians, CMS proposes to use its authority to waive providing mandatory cost category feedback.

7. MIPS Final Score Methodology (§414.1380)

As way of background, under section 1848(q) of the Act the Secretary is directed to:

- Develop a methodology for assessing the total performance of each MIPS eligible clinician according to performance standards for a performance period for a MIPS payment year;
- Using the methodology, provide a final score for each MIPS eligible clinician for each performance period; and
- Using the final score, determine and apply a MIPS adjustment factor (and, as applicable, an additional MIPS adjustment factor) to the MIPS eligible clinician for the MIPS payment year.

For the 2020 MIPS payment, year, CMS intends to build on the scoring methodology it finalized for the transition year. In brief, CMS proposes 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

⁸ The weighted average is calculated as the clinician (or TIN's) summed average HCC risk score multiplied by the number of unique beneficiaries cared for by the clinician (or TIN), then divided by the sum of beneficiaries cared for by each individual clinician (or TIN) in the APM Entity. See section II.C.7.b.(1) for more details.

- Policies that allow multiple pathways for MIPS eligible clinicians to receive a neutral to positive MIPS payment adjustment.

CMS states its belief that these proposed 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 proposed policies that apply across multiple performance categories.

Policies Related to Scoring Improvement

In the 2017 QPP final rule, CMS summarized comments regarding potential ways to incorporate improvement into the scoring methodology, including using approaches based on methodologies used in the Hospital VBP program, the Shared Savings Program, and Medicare Advantage. CMS did not finalize a policy at that time.

CMS states that the options it considered last year are better structured to compare changes in performance based on the same measure from year-to-year, and conclude they are not appropriate for various reasons. CMS believes a category-level approach (rather than a measure-level approach) would provide a broader perspective, particularly in the absence of a standard set of measures, because it would allow for a more flexible approach that enables MIPS eligible clinicians to select measures and data submission mechanisms that can change from year to year and be more appropriate to their practice in a given year.

CMS concludes that a category-level approach would be more appropriate for the quality performance category as clinicians have a variety of different measures which can be submitted by different mechanisms, rather than a standard set of measures or a single data submission mechanism. On the other hand, CMS states that a measure-level approach would be more appropriate for the cost performance category as clinicians are scored on the same set of cost measures and clinicians cannot choose which cost measures they will be scored on.

In brief, CMS proposes 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 is not proposing 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 proposes 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 would continue to be assessed on the full 12- month performance period (January 1 through December 31).

CMS propose an 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 does not provide a specific process for determining “significant”, but anticipates that its determination would include these factors: a more than 10 percent change in codes in the measure numerator, denominator, exclusions, and exceptions; guideline changes or new products or procedures reflected in ICD-10 code changes; and feedback on a measure received from measure developers and stewards.

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

Quality Measure Benchmarks

CMS is not proposing to change the policies on quality measure benchmarking finalized in the 2017 QPP final rule and codified at paragraphs (b)(1)(i) through (iii) of §414.1380.

CMS, however, is proposing a technical correction to paragraphs (i) and (ii) to clarify that measure benchmark data are separated into decile categories based on percentile distribution, and that, other than using performance period data each benchmark must have a minimum of 20 individual clinicians or groups who reported on the measure meeting the data completeness requirement and case minimum case size criteria and performance greater than zero.

CMS is not proposing to change its policies related to stratifying benchmarks by practice size for the 2020 MIPS payment year. For many measures, the benchmarks may not need stratification as they are only meaningful to certain specialties and only expected to be submitted by those specialists. CMS also points out that the current benchmarking approach only compares like clinicians to like clinicians and that stratifying by practice size could have unintended negative consequences for the stability of the benchmarks, equity across practices, and quality of care for beneficiaries.

Assigning Points Based on Achievement

CMS reviews that in the 2017 QPP final rule, it finalized at §414.1380(b)(1) that a MIPS quality measure must have a measure benchmark to be scored based on performance. CMS is not proposing any changes to this policy.

CMS is also not proposing to change the policies to score quality measure performance using a percentile distribution, separated by decile categories and assign partial points based on the percentile distribution finalized in the 2017 QPP final rule. Table 19 in the proposed rule provides an example of assigning points for performance based on benchmarks using a percentile distribution, separated by decile categories

TABLE 19—EXAMPLE OF ASSIGNING POINTS FOR PERFORMANCE BASED ON A BENCHMARK, SEPARATED BY DECILES

Submission mechanism	Measure ID #130 (documentation of current medications in the medical record) *		
	Claims performance benchmark	EHR performance benchmark	Registry/QCDR benchmark
Decile 1 or 2 (3 points)	<96.11	<76.59	<61.27
Decile 3 (3.0–3.9 points)	96.11–98.73	76.59–87.88	61.27–82.11
Decile 4 (4.0–4.9 points)	98.74–99.64	87.89–92.73	82.12–91.71
Decile 5 (5.0–5.9 points)	99.65–99.99	92.74–95.35	91.72–96.86
Submission mechanism	Measure ID #130 (documentation of current medications in the medical record) *		
	Claims performance benchmark	EHR performance benchmark	Registry/QCDR benchmark
Decile 6 (6.0–6.9 points)	—	95.36–97.08	96.87–99.30
Decile 7 (7.0–7.9 points)	—	97.09–98.27	99.31–99.99
Decile 8 (8.0–8.9 points)	—	98.28–99.12	—
Decile 9 (9.0–9.9 points)	—	99.13–99.75	—
Decile 10 (10 points)	100	>= 99.76	100

* Based on our historical benchmark file for the 2017 MIPS performance period.

Floor for Scored Quality Measures

For the 2018 MIPS performance period, CMS proposes to again apply a 3-point floor for each measure that can be reliably scored against a benchmark based on the baseline period.

Additional Policies for the CAHPS for MIPS Measure Score

As way of background, in the 2017 QPP final rule, CMS finalized a policy for the CAHPS for MIPS measure, such that each Summary Survey Measure (SSM) will have an individual benchmark, that it will score each SSM individually and compare it against the benchmark to establish the number of points, and the CAHPS score will be the average number of points across SSMs. CMS proposes to remove two SSMs from the CAHPS for MIPS survey, which would result in the collection of 10 SSMs.

CMS proposes not to score the “Health Status and Functional Status” SSM and the “Access to Specialists” SSM beginning with the 2018 MIPS performance period.

Table 20 in the proposed rule (reproduced below) summarizes the proposed SSMs included in the CAHPS for MIPS survey and illustrates application of CMS’ proposal to score only 8 measures.

Table 20: Proposed SSM for CAHPS for MIPS Scoring

Summary Survey Measure	Proposed for Inclusion in the CAHPS for MIPS Survey?	Proposed 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

As finalized in the 2017 QPP final rule, CMS identified topped-out process measures as those with a median performance rate of 95 percent or higher. CMS estimates (using 2015 historical benchmark data) that about 45 percent of the quality measures, 70 percent of claims measures, 10 percent of EHR measures, and 45 percent of registry/QCDR measures are topped out.

CMS is not proposing 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 and removing them may impact the ability of some MIPS eligible clinicians to submit 6 measures and may impact some specialties more than others. CMS notes that the topped out designation and special scoring apply only to the specific benchmark that is topped out, not necessarily every benchmark for a measure. For example, a measure could be topped out for the claims submission measure, but not the EHR submission measure.

CMS proposes to cap the score of topped out measures at 6 measure achievement 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 believes this cap would only be used for a few years. CMS states that its rationale for a 6-point cap is that 6 points is the median score for any measure as it represents the start of the 6th decile for performance and represents the spot between the bottom 5 deciles and start of the top 5 deciles.

CMS proposes to apply the special topped out scoring method that it finalizes 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. Table 21 in the proposed rule (reproduced here) details the proposed topped out measure for special scoring for the 2018 MIPS performance period.

Table 21: 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

Measure Name	Measure ID	Measure Type	Topped Out for All Submission Mechanisms	Specialty Set
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

Starting with the 2019 performance period, CMS proposes to apply the special topped out scoring method to all topped out measures, provided it is the second (or more) consecutive year the measure is identified as topped out.

CMS provides the following lifecycle for scoring and removing topped out measures based on its proposals 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 21 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. All measure benchmarks identified as topped out for the second (or more) consecutive year would have special scoring applied for the 2019 MIPS performance period. In addition, CMS would also consider removal of the select set of topped out measures identified in Table 21, through notice and comment rulemaking, provided they are identified as topped out during the previous two (or more) consecutive years.

Year 4	Measure benchmarks are identified as topped out in the benchmarks published for the 2020 MIPS performance period. Measure benchmarks identified as topped out for a second (or more) consecutive year continue to have special scoring applied. Topped out measures finalized for removal for the 2020 MIPS performance period would be no longer available for reporting.
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CMS proposes certain exception to applying special scoring adjustments to topped out measures. Because of the lack of ability to select measures, CMS is not proposing to apply a special scoring adjustment to topped out measures for 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. Thus, CMS is not proposing to apply the topped out measure cap to measures in the CMS Web Interface for the QPP.

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 is not proposing 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 proposes to maintain the policy to assign 3 points for measures that are submitted but do not meet the required case minimum or does not have a benchmark for the 2020 MIPS payment year.

CMS proposes a change to the policy for scoring measures that do not meet the data completeness requirement for the 2020 MIPS payment year. Specifically, CMS proposes 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 plans to assign zero points for measures that do not meet the completeness standards in the future. CMS proposes an exception to the proposed policy for small practices.

CMS provides a summary of the proposals in Table 23 of the proposed rule (reproduced below)

Table 23: Quality Performance Category: Scoring Measures Based on Performance

Measure type	Description in transition year	Scoring rules in 2017 MIPS performance period	Description proposed for 2018 MIPS performance period	Proposed for 2018 MIPS performance period
Class 1	Measures that can be scored based on performance. Measures that were submitted or calculated that met the following criteria: The measure has a benchmark; Has at least 20 cases; and (3) Meets the data completeness standard (generally 50 percent).	3 to 10 points based on performance compared to the benchmark.	Same as transition year.	Same as transition year. 3 to 10 points based on performance compared to the benchmark.
Class 2	Measures that cannot be scored based on performance. Measures that were submitted, but fail to meet one of the Class 1 criteria. The measure either does not have a benchmark, does not have at least 20 cases, or does not meet data completeness criteria.	3 points * This Class 2 measure policy does not apply to CMS Web Interface measures and administrative claims based measures.	Measures that were submitted and meet data completeness, but does not have one or both of the following: (1) a benchmark (2) at least 20 cases.	3 points *This Class 2 measure policy would not apply to CMS Web Interface measures and administrative claims based measures.
Class 3	n/a	n/a	Measures that were submitted, but do not meet data completeness criteria, regardless of whether they have a benchmark or meet the case minimum.	1 point except for small practices, which would receive 3 points. *This Class 3 measure policy would not apply to CMS Web Interface measures and administrative claims based measures.

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

In the 2017 QPP final rule, CMS finalized that MIPS eligible clinicians who fail to submit a measure that is required to satisfy the quality performance category submission criteria would receive zero points for that measure. CMS is not proposing any changes to the policy in this proposed rule.

CMS proposes to validate the availability and applicability of measures only if a MIPS eligible clinician submits via claims submission options only, registry submission options only, or a combination of claims and registry submission options. In these cases, CMS proposes that it will apply the validation process to determine if other measures are available and applicable broadly across claims and registry submission options.

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 may reweight their score according to the reweighting policies described in the proposed rule.

Incentives to Report High Priority Measures

With respect to 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 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. CMS also finalized 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 is not proposing any changes to these policies for awarding measure bonus points for reporting high priority measures in this proposed rule. CMS is also not proposing 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. 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. In addition, CMS finalized that the CEHRT bonus would be available to all submission mechanisms except claims submissions.

CMS is not proposing 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

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 is not proposing any changes to the policy to score the measures with the highest number of assigned points in this proposed rule; however, CMS is proposing refinements to account for measures being submitted across multiple submission mechanisms.

CMS is proposing, 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 believes that this will provide additional options for MIPS eligible clinicians to report the measures required to meet the quality performance category criteria and begin to use electronic submission mechanisms.

Consistent with the rest of MIPS, CMS will 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 clarifies 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 24 (reproduced here) summarizes the submission mechanisms and what quality measures can be scored across multiple mechanisms.

Table 24: 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.
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CMS makes several proposals to how measures will be scored:

- If a MIPS eligible clinician submits the same measure via 2 different submission mechanisms, CMS proposes to score each mechanism by which the measure is submitted for achievement and take the highest measure achievement points of the 2 mechanisms.
- CMS proposes to calculate total measure achievement points by using the measures with the 6 highest measure achievement points across multiple submission mechanisms.
- CMS proposes that 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. CMS states that the rationale for providing measure bonus points for measures that do not contribute measure achievement points to the quality performance category percent score is that it would help create better benchmarks for outcome and other high priority measures by encouraging clinicians to report them even if they may not have high performance on the measure.
- CMS proposes that if the same measure is submitted through multiple submission mechanisms, CMS would apply the bonus points only once to the measure. This is reflected in §414.1380(b)(1)(xv) (as redesignated). CMS notes, however, that it does not encourage clinicians to submit the same measure via multiple mechanisms. If the same measure (as determined by measure ID) is submitted, then CMS would use the highest achievement points for that measure.

Table 25 in the proposed rule provides an example illustrating assignment of total achievement and bonus points where measures are submitted across multiple submission mechanisms.

TABLE 25—EXAMPLE OF ASSIGNING TOTAL MEASURE ACHIEVEMENT AND BONUS POINTS FOR AN INDIVIDUAL MIPS ELIGIBLE CLINICIAN THAT SUBMITS MEASURES ACROSS MULTIPLE SUBMISSION MECHANISMS

	Measure achievement points	6 Scored measures	High priority measure bonus points	Incentive for CEHRT measure bonus points
<i>Registry</i>				
Measure A (Outcome)	7.1	7.1 (Outcome measure with highest achievement points).	(required outcome measure does not receive bonus points).	
Measure B	6.2 (points not considered because it is lower than the 8.2 points for the same claims measure).			
Measure C (high priority patient safety measure that meets requirements for additional bonus points).	5.1 (points not considered because it is lower than the 6.0 points for the same claims measure).		1	

<i>Claims</i>				
Measure A (Outcome)	4.1 (points not considered because it is lower than the 7.1 points for the same measure submitted via a registry).	No bonus points because the registry submission of the same measure satisfies requirement for outcome measure.	
Measure B	8.2	8.2		
Measure C (High priority patient safety measure that meets requirements for additional bonus points).	6.0	6.0	No bonus (Bonus applied to the registry measure).	
Measure D (outcome measure <50% of data submitted).	1.0	1.0	(no high priority bonus points because below data completeness).	
<i>EHR (using end-to-end)</i>				<i>Reporting that meets CEHRT bonus point criteria</i>
Measure E	5.1	5.1		1
Measure F	5.0	5.0		1
Measure G	4.1		1
Measure H	4.2	4.2		1
Measure I (high priority patient safety measure that is below case minimum).	3.0	(no high priority bonus points because below case minimum).	1
	35.6	1 (below 10% cap ¹).	5 (below 10% cap).	
Quality Performance Category Percent Score Prior to Improvement Scoring.		(35.6 + 1 + 5)/60 = 69.33%	

¹ In this example the cap would be 6 points, which is 10 percent of the total available measure achievement points of 60.

CMS proposes that if a MIPS eligible clinician submits measures via claims, qualified registry, EHR, or QCDR submission options, and submits more than the required number of measures, they are scored on the required measures with the highest assigned measure achievement points.

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.

CMS proposes 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 makes this proposal in order to continue to align with the 3-point floor for other measures and because the Shared Savings Program does not publish benchmarks with values below the 30th percentile.

CMS is 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.

However, CMS also proposes to exclude CMS Web Interface measures from scoring if the measure is redesignated from pay for performance to pay for reporting for all Shared Savings Program ACOs. CMS proposes that CMS Web Interface measures that have a measure benchmark but are redesignated as pay for reporting for all Shared Savings Program ACOs will not be scored, as long as the data completeness requirement is met.

(3) Scoring the Cost Performance Category

CMS proposes 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 proposes a number of changes in this rule. In brief, CMS proposes to add improvement scoring to the cost performance category scoring methodology starting with the 2020 MIPS payment year. CMS does not propose any changes to for scoring achievement in this category other than the method used for facility-based measurement. CMS proposes to provide that 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.

Measuring Improvement

Calculating Improvement at the Cost Measure Level. For the cost performance category, similar to the quality performance category, CMS proposes 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 proposes to measure cost improvement at the measure level for the cost performance category.

CMS proposes a different data sufficiency standard for the cost performance category than for the quality performance category. Specifically, CMS proposes that it would calculate a cost improvement score only when data sufficient to measure improvement is available. CMS proposes that sufficient data would 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 is not available, CMS proposes to assign a cost improvement score of zero percentage points.

Improvement Scoring Methodology. CMS propose 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 proposes 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 would be possible for the total per capita cost measure and the MSPB measure. These are the 2 measures available for 2 consecutive performance periods under its proposal. The cost improvement score under this methodology can only be a positive amount.

CMS proposes to determine whether there was a significant improvement or decline in performance between the 2 performance periods by applying a common standard statistical test, a t-test, consistent with the approach used in the Shared Savings Program.

Based on its proposal to weight the cost performance category at zero percent for the 2020 MIPS payment year, CMS proposes that although improvement would be measured according to the method described above, the maximum cost improvement score for the 2020 MIPS payment year would be zero percentage points.

Calculating the Cost Performance Category Percent Score with Achievement and Improvement

CMS reviews two different approaches used in other CMS programs for incorporating improvement into its MIPS final score methodology. One method (used by the Hospital VBP program) measures both achievement and improvement and takes the higher of the 2 scores for each measure that is compared. The second method (used by the Shared Savings Program) is to calculate an achievement score and then add an improvement score if improvement is measured.

CMS proposes to add improvement to an existing category percent score for the cost performance category. This is the same approach proposed for the quality performance category. CMS believes this is the most straightforward and simple way to incorporate improvement.

The formula would be:

$$(\text{Cost Achievement Points}/\text{Available Cost Achievement Points}) + (\text{Cost Improvement Score}) = (\text{Cost Performance Category Percent Score}).$$

The total cannot exceed 100 percent

CMS provides an example in Table 32 (reproduced below) in the proposed 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 alternative proposal of a maximum cost improvement score of 1.

TABLE 32: 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

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 proposed 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. For the 2020 MIPS payment year, if CMS finalizes the cost performance category weight of zero percent, then the cost performance category percent score will not contribute to the final score.

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

Facility-Based Measurement

CMS proposes 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. 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.

Facility-Based Measurement Applicability

General Issue. CMS seeks to limit the potential applicability of facility-based measurement to those MIPS eligible clinicians with a significant presence in the hospital.

CMS proposes that a MIPS eligible clinician is eligible for facility-based measurement under MIPS if they are determined facility-based as an individual. CMS further proposes 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 does 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 would 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 2020 MIPS payment year CMS would use the data available at the end of October 2017 to determine whether a MIPS eligible clinician is considered facility-based by its definition.

Facility-Based Measurement Group Participation. CMS is also proposing 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 proposes 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.

Facility Attribution for Facility-Based Measurement

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

Election of Facility-Based Measurement

CMS proposes that 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 also proposes that those clinicians or groups who are eligible for and wish to elect facility-based measurement would be required to submit their election during the data submission period through the attestation submission mechanism established for the improvement activities and ACI performance categories. CMS, if technically feasible, would let the MIPS eligible clinician know that they were eligible for facility-based measurement prior to the submission period.

Facility-Based Measures

CMS provides an overview of the Hospital VBP program and its applicability for use in MIPS for facility-based measures. For the FY 2019 program year, the Hospital VBP Program has adopted 13 quality and efficiency measures and includes 4 domains: person and community

engagement, clinical care, safety, and efficiency and cost reduction. CMS believes that many of measures and domains of the Hospital VBP programs closely align with MIPS high priority measures in the quality performance category and cost performance category.

CMS proposes that facility-based individual MIPS eligible clinicians or groups that are attributed to a hospital would be scored on all the measures on which the hospital is scored for the Hospital VBP Program via the Hospital VBP Program's Total Performance Score (TPS) scoring methodology. In addition, CMS proposes that there are no data submission requirements for the facility-based measures used to assess performance in the quality and cost performance categories, other than electing the option through attestation.

Table 33 in the proposed rule (reproduced here) details the Hospital VBP Program's FY 2019 measures, and their associated performance periods,

Table 33: FY 2019 Hospital VBP Program Measures

Short Name	Domain/Measure Name	NQF #	Performance Period
Person and Community Engagement Domain			
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (including Care Transition Measure)	0166 (0228)	CY 2017
Clinical Care Domain			
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization	0230	July 1, 2014 – June 30, 2017
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization	0229	July 1, 2014 – June 30, 2017
MORT-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization.	0468	July 1, 2014 – June 30, 2017
THA/TKA	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550	January 1, 2015 – June 30, 2017
Safety Domain			
CAUTI	National Healthcare Safety Network (NHSN) CatheterAssociated Urinary Tract Infection (CAUTI) Outcome Measure.	0138	CY 2017
CLABSI	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139	CY 2017
Colon and Abdominal Hysterectomy SSI	American College of Surgeons—Centers for Disease Control and Prevention (ACS–CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure.	0753	CY 2017

Short Name	Domain/Measure Name	NQF #	Performance Period
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) Bacteremia Outcome Measure	1716	CY 2017
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset <i>Clostridium difficile</i> Infection (CDI) Outcome Measure	1717	CY 2017
PSI-90*	Patient Safety for Selected Indicators (Composite Measure)	0531	July 1, 2015 – June 30, 2017
PC-01	Elective Delivery	0469	CY 2017
Efficiency and Cost Reduction Domain			
MSPB	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	2158	CY 2017

* PSI-90 has been proposed in the FY 2018 IPPS/LTCH PPS proposed rule for removal beginning with the FY 2019 program year.

Scoring Facility-Based Measurement

CMS proposes that facility-based scoring is 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 proposes 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 provides an illustrative example in its proposal. For example, if the median Hospital VBP Program Total Performance Score was 35 out of 100 possible points and the median quality performance category percent score in MIPS was 75 percent and the median cost performance category score was 50 percent, then a clinician or group that is evaluated based on a hospital that received an Hospital VBP Program Total Performance Score of 35 points would receive a score of 75 percent for the quality performance category and 50 percent for the cost performance category. The percentile distribution for both the Hospital VBP Program and MIPS would be based on the distribution during the applicable performance periods for each of the programs and not on a previous benchmark year.

Scoring Improvement for Facility-Based Measurement

CMS notes that the Hospital VBP Program includes a methodology for recognizing improvement on individual measures which is then incorporated into the total performance score for each participating hospital. A hospital's performance on a measure is compared to a national benchmark as well as its own performance from a corresponding baseline period.

In this proposed rule, CMS has proposed to consider improvement in the quality and cost performance categories, but does not believe this is necessary for facility-based measurement.

CMS does not propose any additional improvement scoring for facility-based measurement for either the quality or cost performance category

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 states 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.

Bonus Points for Facility-Based Measurement

CMS is not proposing to calculate additional high priority bonus points for facility-based measurement. CMS is not proposing to calculate additional end-to-end electronic reporting bonus points for facility-based measurement as the Hospital VBP Program does not capture this information.

Special Rules for Facility-Based Measurement

CMS proposes that MIPS eligible clinicians who are facility-based and affected by extreme and uncontrollable circumstances, such as natural disasters, may apply for reweighting. CMS also states that it intends to use the final Hospital VBP Total Performance Score for the facility-based measurement option under MIPS. In the event that a hospital obtains a successful correction or appeal of its Total Performance Score, CMS would update MIPS eligible clinicians' quality and cost performance category scores accordingly, as long as the update could be made prior to the application of the MIPS payment adjustment for the relevant MIPS payment year.

Consistent with its other policies, CMS proposes to adopt a floor on the Hospital VBP Program Total Performance Score for purposes of facility-based measurement under MIPS so that any score in the quality performance category, once translated into the percentile distribution described above, that would result in a score of below 30 percent would be reset to a score of 30 percent in the quality performance category. CMS notes that there is no similar floor established for measures in the cost performance category under MIPS, so it did not propose any floor for the cost performance category for facility-based measurement.

CMS proposes at §414.1380(e)(6)(v)(A) that MIPS eligible clinicians who elect facility-based measurement would not be scored on other cost measures specified for the cost performance category, even if they meet the case minimum for a cost measure. CMS states its belief that including additional cost measures in the cost performance category score for MIPS eligible

clinicians who elect facility-based measurement would reduce the alignment of incentives between the hospital and the clinician.

In a situation where a clinician or a group elects facility-based measurement but also submits quality data through another MIPS mechanism, CMS proposes to use the higher of the two scores for the quality performance category and base the score of the cost performance category on the same method (that is, if the facility-based quality performance category score is higher, facility-based measurement is used for quality and cost).

(4) Scoring the Improvement Activities Performance Category

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

With respect to the self-identification policy for MIPS Eligible Clinicians, CMS proposes that beginning with the 2018 MIPS performance period, to no longer require these self-identifications for a non-patient facing MIPS eligible clinician, a small practice, a practice located in a rural area, or a practice in a geographic HPSA or any combination thereof. CMS notes that its now technically feasible to identify these MIPS eligible clinicians during attestation to the performance of improvement activities following the performance period.

(5) Scoring the Advancing Care Information Performance Category

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

b. Calculating the Final Score

(1) Accounting for Risk Factors

MACRA requires CMS to consider risk factors in its scoring methodology. In this section, CMS summarizes its efforts related to social risk. CMS also proposes some short-term adjustments to address patient complexity.

(a) Complex Patient Bonus

CMS proposes to implement a short-term strategy for the QPP to address the impact patient complexity may have on final scores. CMS' stated overall goal when considering a bonus for complex patients is twofold: (1) to protect access to care for complex patients and provide them with excellent care; and (2) to avoid placing MIPS eligible clinicians who care for complex patients at a potential disadvantage while CMS reviews the completed studies and research to address the underlying issues. CMS uses the term “patient complexity” broadly to include such factors as health status and medical conditions of patients, as well as social risk factors.

Because this bonus is intended to be a short-term strategy, CMS proposes the bonus only for the 2018 MIPS performance period (2020 MIPS payment year) and will assess on an annual basis.

In its review, CMS identified two potential indicators for complexity: medical complexity as measured through Hierarchical Condition Category (HCC) risk scores, and social risk as measured through the proportion of patients with dual eligible status. Both of these indicators have been used in Medicare programs to account for risk and both data elements are already publicly available.

With respect to HCC risk scores, risk scores are based on a beneficiary's age and sex; whether the beneficiary is eligible for Medicaid, first qualified for Medicare on the basis of disability, or lives in an institution (usually a nursing home); and the beneficiary's diagnoses from the previous year. The HCC model was designed for risk adjustment on larger populations, such as the enrollees in an MA plan, and generates more accurate results when used to compare groups of beneficiaries rather than individuals. HCC risk scores have also been used in the VM to apply an additional upward payment adjustment. This risk adjustment model is also regularly updated. For more information on the HCC risk score, see: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvigSpecRateStats/Risk-Adjustors.html>

CMS notes that a mean HCC risk score for a MIPS eligible clinician can be calculated by averaging the HCC risk scores for the beneficiaries cared for by the clinician. CMS states that using the HCC risk score as a proxy for patient complexity is a helpful starting point, and that it will explore methods for further distinguishing complexity from other reasons a clinician could receive a high average HCC risk score.

As a proxy for social risk factors, CMS also considered identifying patients dually eligible for Medicare and Medicaid. Dual eligibility has been used in the Medicare Advantage 5-star methodology⁹ and stratification by proportion of dual eligibility status is proposed for the Hospital Readmissions Reduction Program (82 FR 19959-19961).

In its evaluation, CMS evaluated both indicators (average HCC risk score and proportion dual eligible status) using the 2015 Physician and Other Supplier PUF and observed modest correlation between these two indicators. CMS also assessed the correlation of these indicators with MIPS final scores based on performance and the small practice bonus for MIPS eligible clinicians, as well as variations by practice size, submission mechanism, and specialty. Tables 34, 35, and 36 in the proposed rule detail the results. In brief, CMS found that MIPS eligible clinicians in larger practices had slightly higher risk scores than those in small practices and that the average HCC risk score varied by specialty, with nephrology having the highest average HCC risk score (3.05) and dermatology having the lowest (1.24).

⁹ Centers for Medicare & Medicaid Services. Medicare 2017 Part C & D Star Rating Technical Notes. Available at <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2017-Part-Cand-D-Medicare-Star-Ratings-Data-v04-04-2017-.zip>.

For the 2020 MIPS payment year, CMS proposes a complex patient bonus based on the average HCC risk score because this is the indicator that clinicians are familiar with from the VM. Furthermore, CMS proposes at §414.1380(c)(3) 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 would be calculated using the model adopted under section 1853 of the Act for Medicare Advantage risk adjustment purposes.
- HCC risk scores would be an average for by the MIPS eligible clinician or clinicians in the group.
- Time period for purposes of average HCC risk scores would 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)

CMS proposes the second 12-month segment of the eligibility period to align with other MIPS policies to ensure it has sufficient time to determine the necessary calculations.

HCC risk scores for beneficiaries would be calculated based on the year immediately prior to the performance period. For the 2018 MIPS performance period, the HCC risk scores would 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 believe this approach mitigates the risk of “upcoding” to get higher expected costs.

For MIPS APMs and virtual groups, CMS proposes to use 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, as the complex patient bonus. CMS would calculate the weighted average by taking the sum of the individual clinician’s (or TIN’s as appropriate) average HCC risk score multiplied by the number of unique beneficiaries cared for by the clinician and then divide by the sum of the beneficiaries cared for by each individual clinician (or TIN as appropriate) in the APM Entity or virtual group.

CMS proposes at §414.1380(c)(3)(iii) that the complex patient bonus cannot exceed 3 points. CMS stated that it selected this value because the differences in performance observed between simulated scores between the first and fourth quartiles of average HCC risk scores was approximately 4 points for individuals and approximately 5 points for groups. CMS believes that applying this bonus to the final score is appropriate because caring for complex and vulnerable patients can affect all aspects of a practice and not just specific performance categories.

To receive the complex patient bonus, CMS proposes 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 this bonus on average would range from 1.16 points in the first quartile based on HCC risk scores to 2.49 points in the fourth quartile for individual reporters submitting 6 or more measures, and 1.26 points in the first quartile to 2.23 points in the fourth quartile for group reporters.

Small Practice Bonus for the 2020 MIPS Patient Year

CMS believes an adjustment to the final score for MIPS eligible clinicians in small practices (referred to by CMS as the “small practice bonus”) is appropriate to recognize these barriers and to incentivize MIPS eligible clinicians in small practices to participate in the QPP.

To receive the small practice bonus, CMS proposes 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).

CMS proposes to add a small practice bonus of five points to the final score for MIPS eligible clinicians who participate in MIPS for the 2018 MIPS performance period and are in small practices or virtual groups or APM entities with 15 or fewer clinicians. The entire virtual group or APM entity combined must include 15 or fewer clinicians to qualify for the bonus.

CMS notes 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 in its review of its data differences between scores for MIPS eligible clinicians who practice in rural areas and those who do not was minimal. Thus, CMS is not proposing to extend the final score bonus to those who practice in rural areas, but states that it will continue to monitor this issue.

(2) Final Score Calculation

CMS propose to revise the final score calculation to incorporate the addition of the complex patient and small practice bonuses. CMS proposes to 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 proposes to add to §414.1380(c) 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 proposal is necessary to account for its proposal 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.

With these proposed changes, CMS also proposes to strike the following phrase from the final score definition at §414.1305: “The final score is the sum of each of the products of each

performance category score and each performance category's assigned weight, multiplied by 100." CMS states that this portion of the definition would be incorrect and redundant of the proposed revised regulation at §414.1380(c).

(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 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 proposes to change the weight of the cost performance category to zero percent and to change the weight of the quality performance category to 60 percent for the 2020 MIPS payment year (instead of 10 percent for the cost performance category and 50 percent for the quality performance category 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.

The Secretary also has flexibility to reduce the applicable percentage weight of the ACI performance category in the final score (not below 15 percent) in any year in which the proportion of eligible professionals who are meaningful EHR users is 75 percent or greater.

Table 37 in the proposed 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 and its proposals.

TABLE 37: Finalized and Proposed Weights by MIPS Performance Category*

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

* CMS proposes to maintain the same weights from the transition year for the 2020 MIPS payment year for quality and cost (60 percent and zero percent, respectively).

**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.

Redistributing Performance Category Weights

Table 38 in the proposed rule (reproduced below) summarizes the potential reweighting scenarios based on CMS' proposals for the 2020 MIPS payment year should the cost performance category be weighted at zero percent. For example, in the rare event a MIPS eligible clinician is not scored on at least one measure in quality performance category – either because there are not sufficient measures or clinician faces extreme and uncontrollable circumstances – CMS would redistribute the 60 percent weight of the quality performance category so that the performance category weights are 50 percent for the advancing care information performance category and 50 percent for the improvement activities performance category (assuming these performance categories do not qualify for reweighting).

Table 38: Proposed Performance Category Redistribution Policies for the 2020 MIPS Payment Year If the Cost Performance Category Weight is Zero Percent

Performance Category	Weighting for the 2020 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%

8. MIPS Payment Adjustments

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

No changes are 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 APM 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.

- For groups submitting data using the TIN identifier, CMS will apply the group final score to all 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 in 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) 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, 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.
- In cases, where a TIN/NPI has multiple final scores from a performance period, the hierarchy will be to use the APM Entity final score if there is one, to use the highest APM Entity final score if there is more than one, and if there is no APM Entity score, to calculate a final score for the group and individual identifier and use the highest final score for the TIN/NPI.

In addition to these clarifications, CMS proposes to modify these policies for assignment of a final score to account for the addition of virtual groups, which is proposed elsewhere in this rule. Under the proposal, CMS says “it must” prioritize the virtual score over other final scores, but because it wishes to encourage movement towards APMs, it would prioritize the APM Entity final score over any other score for a TIN/NPI, including one that is a virtual group.

The previously and finalized hierarchies and the proposed hierarchies involving virtual groups are summarized in Tables 40 and 41 of the proposed rule, reproduced below.

TABLE 40: 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 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 41: 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 are 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

For the transition year (CY 2017 Performance Period), the performance threshold was set at only 3 points, meaning that clinicians achieving this score or higher will not receive a negative payment adjustment. This low performance threshold was intended to encourage participation and provide an opportunity for clinicians to become familiar with the MIPS Program. CMS stated its intention to increase the performance threshold of the MIPS for the 2020 payment year and beginning with 2021 to use the mean or median final score from a prior period as required by statute.

CMS proposes that for the 2020 payment year, the performance threshold be set at 15 points, which it believes represents a meaningful increase in the performance threshold while maintaining flexibility for clinicians to achieve the threshold in multiple ways. For example, CMS notes that submitting the maximum number of improvement activities could result in a score of 15 points (40 out 40 possible points for the improvement activity which is worth 15 percent of the final score). The performance threshold could also be met by full participation in the quality performance category, where eligible clinicians would earn at least a quality performance category percent score of 30 percent by meeting data completeness for submitting all required measures (3 measure achievement points out of 10 measure points for each required measure) and resulting in a quality performance score of 18 points. (30 percent x 60 percent category weight x 100).

Finally, a MIPS eligible clinician could achieve a final score of 15 points through an ACI performance category score of 60 percent or higher (60 percent x 25 percent category weight x 100).

Using 2015 PQRS data, CMS estimated that 92 percent of MIPS-eligible clinicians submitted data to PQRS but just under 70 percent of clinicians in small practices did so. It believes that a low threshold will help small practices learn to participate and perform well in MIPS without excessive financial risk.

d. Additional Performance Threshold for Exceptional Performance

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

e. Application of the MIPS Payment Adjustment Factors

As previously codified, 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 proposes 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 would be unaffected by the application of the MIPS adjustment factors. Readers are referred to section II.C.3.e of the proposed rule for further discussion and proposals regarding which Part B covered items and services would be subject to the MIPS payment adjustment.

f. Example of MIPS Adjustment Factors

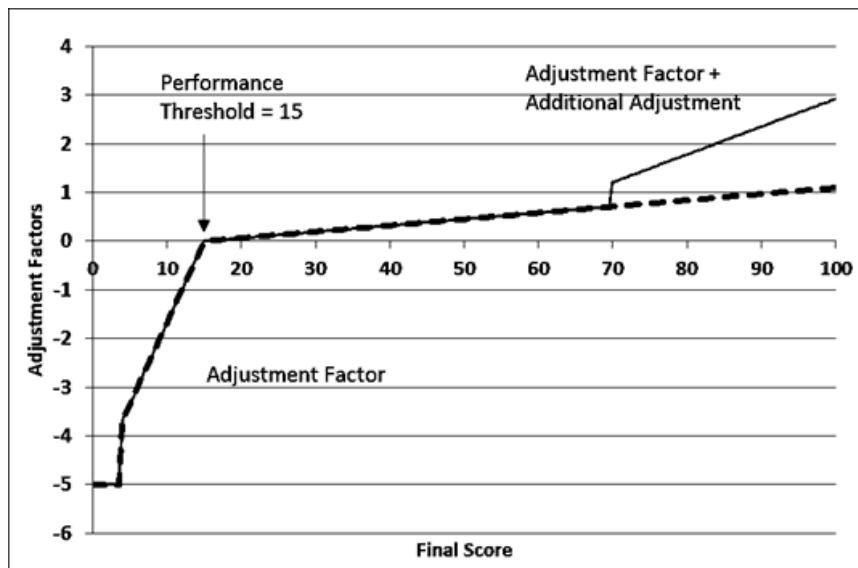
Figure A, copied below from the proposed rule, illustrates how scores would be converted into adjustment factors. For 2020, the performance threshold is 15 points, and the applicable percentage is 5 percent. As shown, clinicians with a final score of 15 will receive a 0 percent adjustment. The scale 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 points will be less than 5 percent.

In Figure A, the illustrative budget neutrality scaling factor is 0.22; MIPS eligible clinicians with a final score of 100 would receive an adjustment factor of 1.1 percent ($5.0\text{ percent} \times 0.22$). The proposed additional performance threshold is 70. A score of 70 would receive an additional adjustment factor of 0.5 percent and the factor will increase to the statutory maximum 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 0.183; a clinician with a final score of 100 would receive an additional adjustment factor of 1.83 percent ($10\text{ percent} \times 0.183$), and therefore a total adjustment of 2.93 percent ($1.1\text{ percent} + 1.83\text{ percent}$).

Table 42 in the proposed rule compares the point system and associated adjustment adopted for the transition year to the approach proposed for the 2020 MIPS payment year.

The proposed rule also includes three examples of how MIPS eligible clinicians can achieve a final score at or above the proposed 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.

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



9. Review and Correction of Final Score

a. Performance feedback

In this rule, CMS proposes to provide performance feedback to MIPS-eligible clinicians and groups 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 if technically feasible. This feedback would be provided annually, and more frequently, such as quarterly, if technically feasible. CMS also proposes that the measures and activities specified for the 2017 performance period for all four performance categories along with the final score would be included in performance feedback provided on or about July 1, 2018.

MIPS APM participants. As noted above in section II.A.6.g., beginning in 2018, MIPS eligible clinicians who participate in MIPS APMs would receive performance feedback in 2018 if technically feasible.

Clinicians who are not MIPs eligible. Performance feedback would 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 would be with respect to data voluntarily reported and collected during the 2017 performance period. CMS believes that providing this feedback will help clinicians who may be considered MIPS eligible in future years; would provide all clinicians equal access to claims and benchmarking data provided; and would assist clinicians considering participation in an APM in making an informed decision.

Information on other Medicare expenditures. As required by statute, CMS proposes 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 proposes to 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
- Dates that items and services were furnished.

Further, CMS proposes that the additional information would include historical data on total allowed charges, component charges, and other figures as determined appropriate. The information would be provided at the aggregate level. CMS notes that it could consider providing data on items and services at the patient level, if clinicians find this to be useful, although it may contain personally identifiable information and protected health information. Regarding the date range, CMS says it would provide information based on what is most helpful to clinicians. The most recent data available, as technically feasible, would be provided from a 3-month to a 12- month period. The information would be made available via the QPP website, and as technically feasible, as part of the performance feedback. Finally, because data on items and services furnished are generally kept confidential, CMS proposes that access would be provided only after secure credentials are obtained.

b. Targeted Review

No changes are 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 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

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.

In this rule, CMS proposes to revise 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 would be required to certify to the best of their knowledge that the data submitted to CMS are true, accurate, and complete. The certification would be required to accompany the submission. (In the 2017 QPP final rule, CMS indicated that attestation requirements would be part of the submission process, but failed to codify this in the regulatory text. Subsequently, CMS determined that certification is more appropriate than attestation.)
- If a MIPS eligible clinician or group is found to have submitted inaccurate data for MIPS, CMS would reopen and revise the determination in accordance with the rules set forth at §§405.980 through 405.986.
- MIPS eligible clinicians and groups that submit data and information to CMS for purposes of MIPS would be required retain to such data and information for 10 years from the end of the MIPS performance period

CMS also notes that it will continue to include education and support for MIPS eligible clinicians and groups selected for an audit.

10. Third Party Data Submission

CMS proposes that third party intermediaries may submit data on behalf of “virtual groups” in addition to a MIPS eligible clinician or group. It also proposes that all data submitted to CMS by a third party intermediary on behalf of a MIPS eligible clinician, group or virtual group must be certified by the third party intermediary to the best of its knowledge as true, accurate, and complete. The certification must occur at the time of and accompany the submission.

a. Qualified Clinical Data Registries (QCDRs)

Establishment of an Entity Seeking to Qualify as a QCDR. CMS finalized the criteria for an entity to qualify as a QCDR in the CY 2017 QPP final rule (81 FR 77365). CMS is not proposing any changes to these criteria for CY 2018.

Self-Nomination Period. CMS is proposing, beginning with the 2019 performance period, a simplified process in which existing QCDRs in good standing may continue their participation in MIPS, by attestng that the QCDR’s approved data validation plan, cost, measures, activities, services, and performance categories offered in the previous year’s performance period of MIPS

have minimal or no changes for the upcoming performance period. Existing QCDRs in good standing, may also submit for CMS review and approval, substantive changes to measure specifications for existing QCDR measures that were approved the previous year, or submit new QCDR measures for CMS review and approval without having to complete the entire self-nomination application process.

For FY 2018, CMS proposes that self-nomination information must be submitted via a web-based tool eliminating the submission by email. CMS will provide further information on the web-based tool at <http://www.qpp.cms.gov>.

Information Required at the Time of Self-Nomination. CMS is not proposing any changes to the information a QCDR must provide but proposes to refer to this information as “QCDR measures” rather than “non-MIPS measures.”

QCDR Criteria for Data Submission. CMS is not proposing any changes to the existing criteria but notes the following clarifications:

- QCDR measures, and their data elements must be listed on the QCDR’s website unless the measure is a MIPS measure.
- It is optional for approved QCDRs to post the MIPS quality measure specifications on their website but if posted, the measures must replicate exactly the MIPS quality measure specifications posted on the CMS website.
- QCDRs must enter into and maintain with its participating MIPS eligible clinicians an appropriate Business Associate agreement that complies with the HIPAA Privacy and Security Rules.
- QCDRs must provide timely feedback at least 4 times a year, on all of the MIPS performance categories that the QCDR will report to CMS.
- For purposes of distributing performance feedback to MIPS eligible clinicians, CMS encourages QCDRs to assist MIPS eligible clinicians in the update of their email addresses in CMS systems – including PECOS and the Identity and Access System - so that they have access to feedback as it becomes available on [qpp.cms.gov](http://www.qpp.cms.gov) and have documentation from the MIPS eligible clinician authorizing the release of his or her email address.

CMS further explains that QCDRs will only be able to request review and approval for additional MIPS measures through the performance period—there will be no additions of new QCDR measures. QCDRs will not be able to retire any measures during the performance period.

QCDR Measure Specifications Criteria.

CMS specified QCDR measures specifications criteria in the CY 2017 QPP final rule (81 FR 77374-77375) and indicates that it generally intends to apply a process similar to the one used for MIPS measures to QCDR measures that have been identified as topped out. While CMS is not proposing any changes to the QCDR measure specifications criteria it notes the following:

- Encourages alignment with the MIPS measures development plan, but will consider all QCDR measures submitted by the QCDR.

- Expects that a QCDR reporting on MIPS measures retain and use the MIPS specifications as they exist for the performance period.
- Clarifies it will likely not approve retired measures that were previously in one of CMS's quality programs, such as the Physician Quality Reporting System (PQRS) program, if proposed as QCDR measures including topped out measures and retired measures because evidence no longer supports its use.

Beginning with the 2018 performance period and for future program years, CMS proposes that QCDR vendors may seek permission from another QCDR to use an existing measure that is owned by the other QCDR. Permission must be granted at the time of the self-nomination and proof of permission provided to CMS with the self-nomination.

CMS further clarifies that QCDRs must publicly post the measure specifications no later than 15 calendar days following CMS approval of these measure specifications for each QCDR measure intended to be submitted for MIPS.

b. Health IT Vendors That Obtain Data From MIPS Eligible Clinicians' Certified EHR Technology (CEHRT)

CMS finalized definitions and criteria around health IT vendors that obtain data from MIPS eligible clinicians CEHRT in the CY 2017 QPP final rule (81 FR 77382). CMS is not proposing any policy changes but notes that a health IT vendor that serves as a third party intermediary to collect or submit data on behalf MIPS eligible clinicians may or may not also be a "health IT developer." CMS uses the term "health IT vendor" to refer to entities that support the health IT requirements of a clinician participating in the QPP.

c. Qualified Registries

Establishment of an Entity Seeking to Qualify as a Registry. CMS finalized the requirements for the establishment of an entity seeking to qualify as a registry in the CY 2017 QPP final rule (81 FR 77383). CMS is not proposing any changes to this policy.

Self-Nomination Period. CMS is proposing the same changes for qualified registries that apply to QCDRs above. Qualified registries may attest to having minimal or no changes to the approved data validation plan, cost, approved MIPS quality measures, services, and performance categories for the upcoming performance period.

Qualified Registry Criteria for Data Submission. CMS is not proposing any changes to the existing criteria but notes the following clarifications:

- Qualified Registries must enter into and maintain with its participating MIPS eligible clinicians an appropriate Business Associate agreement that complies with the HIPAA Privacy and Security Rules.
- Qualified Registries must provide timely feedback at least 4 times a year, on all of the MIPS performance categories that the QCDR will report to CMS.

Information Required at the Time of Self-Nomination. CMS finalized the information required from qualified registries at the time of self-nomination in the CY 2017 QPP final rule (81 FR 77384). CMS is not proposing any changes to the required information.

Qualified Registry Criteria for Data Submission. CMS finalized the criteria for qualified registry data submission in the CY 2017 QPP final rule (81 FR 77386). CMS is not proposing any changes to these criteria but notes the following clarifications to the existing criteria:

- Enter into and maintain with its participating MIPS eligible clinicians an appropriate Business Associate agreement that complies with the HIPAA Privacy and Security Rules. Ensure that the Business Associate agreement provides for the Qualified Registry's receipt of patient specific data from an individual MIPS eligible clinician or group, as well as the Qualified Registry's disclosure of quality measure results and numerator and denominator data or patient specific data on Medicare and non-Medicare beneficiaries on behalf of individual MIPS eligible clinicians and groups.
- CMS had finalized that timely feedback be provided at least four times a year, on all of the MIPS performance categories that the qualified registry will report.

CMS further noted that it will consider previous comments that suggested raising the 3 percent acceptable error rate for qualified registries to 5 percent because 2017 is the first year of MIPS and removing qualified registries due to a low error threshold could hurt clinicians.

CMS further indicated that it will, on a case-by-case basis, allow qualified registries to request review and approval for additional MIPS measures throughout the performance period. Any new measures that are approved will be added to the information related to the qualified registry on the CMS website, as technically feasible. CMS anticipates only being able to update this information on the website on a quarterly basis, as technically feasible.

d. CMS-Approved Survey Vendors

Beginning with the 2018 performance period and for future program years, CMS proposes to remove the April 30th survey vendor application deadline because this deadline is within the timeframe of when groups can elect to participate in the CAHPS for MIPS survey. CMS proposes that for QPP Year 2 and future years, that the vendor application deadline would be January 31st of the applicable performance year or a later date specified by CMS. CMS will notify vendors of the application deadline to become a CMS-approved survey vendor earlier in the timeframe during which groups can elect to participate in the CAHPS for MIPS survey.

11. Public Reporting on Physician Compare

a. Final Score, Performance Categories and Aggregate Information

CMS is proposing to add the following to Physician Compare:

- The final score for each MIPS eligible clinician;
- The performance of each MIPS eligible clinician for each performance category;

It also proposes to periodically post aggregate information on the MIPS, including the range of final scores for all MIPS eligible clinicians and the range of performance of all the MIPS eligible clinicians for each performance category each year to Physician Compare for each MIPS eligible clinician or group, either on the profile pages or in the downloadable database, as technically feasible. Statistical testing and user testing, as well as consultation of the Physician Compare Technical Expert Panel, will determine how and where these data are best reported on Physician Compare. CMS proposing to include this information each year moving forward, as technically feasible.

b. Quality

CMS is again proposing to make all measures under the MIPS quality performance category available for public reporting on Physician Compare, as technically feasible. This would include all available measures reported via all available submission methods for both MIPS eligible clinicians and groups, for 2018 data available for public reporting in late 2019, and for each year moving forward. These data are required by the MACRA to be available for public reporting on Physician Compare. CMS indicates that continuing to publicly report these data ensures continued transparency and provides people with Medicare and their caregivers valuable information they can use to make informed health care decisions. Even though all measures will be available for public reporting, not all measures will be made available on public-facing website profile pages due to concerns about overwhelming Physician Compare users with too much information and to ensure only valid and reliable data is available.

In addition, CMS seeks comment on expanding the patient experience data available for public reporting on Physician Compare. Currently, the CAHPS for MIPS survey is available for groups to report under the MIPS. The Agency for Healthcare Research and Quality (AHRQ) is fielding a beta version of the CAHPS Patient Narrative Elicitation Protocol (<https://www.ahrq.gov/cahps/surveys-guidance/item-sets/elicitation/index.html>). This includes five open-ended questions designed to be added to the Clinician & Groups CAHPS survey, which CAHPS for MIPS is modeled after. These five questions have been developed and tested to capture patient narratives in a scientifically grounded and rigorous way. For future rulemaking, CMS is considering whether responses to these questions for the CAHPS for MIPS survey should be publicly reported.

c. Cost

CMS is concerned that publicly reporting cost measures could lead to significant misunderstanding and is proposing to only share on the Physician Compare profile pages or in a downloadable database those cost measures that can help patients and caregivers make informed health care decisions. CMS' proposal would apply, if technically feasible, for 2018 data available for public reporting in late 2019, and for each year moving forward. For transparency purposes, the cost measures that meet all other public reporting standards would be included in the downloadable database. Statistical testing and website user testing would determine how and where measures are reported on Physician Compare to minimize passing the complexity of these measures on to patients and to ensure those measures included are accurately understood and correctly interpreted.

Under this proposal, policies previously mentioned regarding first year measures, the minimum reliability threshold, and all public reporting standards would apply. This proposal applies to all available measures reported via all available submission methods, and applies to both MIPS eligible clinicians and groups.

d. Improvement Activities

CMS is again proposing to include a subset of improvement activities data on Physician Compare that meet the public reporting standards, either on the profile pages or in the downloadable database, if technically feasible, for 2018 data available for public reporting in late 2019, and for each year moving forward.

This again includes all available activities reported via all available submission methods, and applies to both MIPS eligible clinicians and groups. For those eligible clinicians or groups that successfully meet the improvement activities performance category requirements this information may be posted on Physician Compare as an indicator. This information is required by the MACRA to be available for public reporting on Physician Compare, but the improvement activities performance category is a new field of data for Physician Compare so concept and website user testing is still needed to ensure these data are understood by stakeholders.

CMS is again proposing that statistical testing and user testing would determine how and where improvement activities are reported on Physician Compare. Starting with year 2 (2018 data available for public reporting in late 2019), CMS proposes publicly reporting first year activities if all other reporting criteria are satisfied.

e. Advancing Care Information (ACI)

CMS is again proposing to include an indicator on Physician Compare for any eligible clinician or group who successfully meets the ACI performance category, as technically feasible. Also, as technically feasible, CMS proposes to include additional indicators, including but not limited to, objectives, activities, or measures such as, identifying if the eligible clinician or group scores high performance in patient access, care coordination and patient engagement, or health information exchange. These proposals would apply to 2018 data available for public reporting in late 2019, and for each year moving forward, as this information is required by the MACRA to be available for public reporting on Physician Compare.

CMS also proposes that any ACI objectives, activities, or measures would need to meet the public reporting standards applicable to data posted on Physician Compare, either on the profile pages or in the downloadable database. This would include all available objectives, activities, or measures reported via all available submission methods, and would apply to both MIPS eligible clinicians and groups. Statistical testing and website user testing would determine how and where objectives and measures are reported on Physician Compare.

As with improvement activities, CMS is also proposing to allow first year advancing care information objectives, activities, and measures to be available for public reporting starting in year 2 (2018 data available for public reporting in late 2019).

f. Achievable Benchmark of Care (ABCTM)

CMS explains that a benchmark allows website users to more easily evaluate information on Physician Compare by providing a point of comparison between groups and between clinicians. Based on stakeholder outreach and the recommendation of a Technical Expert Panel, CMS previously finalized using the Achievable Benchmark of Care (ABCTM) methodology. Results will be posted annually based on the PQRS performance rates most recently available by reporting mechanism.

The ABCTM provides an evaluation of a top performers for a given measure and then allows that evaluation to be a point of comparison for all of those groups or clinicians who report the measure. CMS expects to publicly report the benchmark and 5-star rating for the first time on Physician Compare in late 2017 using the 2016 PQRS performance scores for both clinicians and groups.

To determine star ratings on Physician Compare, CMS decided that an approach of dividing results into deciles was not ideal as it would result in an equal distribution of clinicians in each of the star rating categories. Using the ABCTM methodology, if the majority of clinicians performed well on a measure, the majority would receive a high star rating. CMS reports that testing with website users has shown that star rating based on the ABCTM benchmark helps patients and caregivers interpret the data accurately and it has been historically well received by the clinicians and entities it is measuring. For these reasons, CMS is again proposing to use the ABCTM methodology to determine a benchmark for the quality, cost, improvement activities, and advancing care information data, as feasible and appropriate, by measure and by reporting mechanism for each year of the QPP, starting with the transition year data (2017 data available for public reporting in late 2018). CMS is also proposing to use this benchmark to determine a 5-star rating for each MIPS measure, as feasible and appropriate. The details of how the benchmark will translate to the 5-star rating will be determined in consultation with stakeholders.

g. Voluntary Reporting

Starting with year 2 of the QPP (2018 data available for public reporting in 2019) and for each year moving forward, CMS is proposing to make all data publicly available that is submitted voluntarily by clinicians and groups not subject to MIPS adjustments (such as Rural Health Clinics and Federally Qualified Health Centers). The data made available would be across all MIPS performance categories, regardless of submission method and made available as technically feasible. CMS is further proposing that clinicians and groups voluntarily reporting data could opt out of having their day publicly reported on Physician Compare during the 30-day preview period. Data would be available for inclusion on Physician Compare if the data meet all previously stated public reporting standards and the minimum reliability threshold.

h. APM Data

Section 1848(q)(9)(A)(ii) of the Act requires CMS to publicly report names of eligible clinicians in Advanced APMs and, to the extent feasible, the names and performance of Advanced APMs. Building on its prior experience with Physician Compare, CMS is again proposing to publicly report names of eligible clinicians in Advanced APMs and the names and performance of Advanced APMs and other APMs starting with year 2 (2018 data available for public reporting in late 2019), and for each year moving forward, as technically feasible. In addition, CMS is again proposing to continue to find ways to more clearly link clinicians and groups and the APMs they participate in on Physician Compare, as technically feasible.

i. Stratification by Social Risk Factors

CMS is considering reports from the ASPE and the National Academies of Sciences, Engineering and Medicine on accounting for social risk factors on patient outcomes in the Quality Payment Program. Examples of social risk factor indicators include but are not limited to dual eligibility/low income subsidy, race and ethnicity, social support, and geographic area of residence. **CMS seeks public comment on:**

- Which social risk factors or indicators should be used and from what source through public reporting on Physician Compare;
- The process for accessing or receiving the necessary data to facilitate stratified reporting; and
- Whether strategies such as confidential reporting of stratified rates using social risk factor indicators should be considered in the initial years of the QPP in lieu of publicly reporting stratified performance rates for quality and cost measures under the MIPS on Physician Compare

B. Overview of Incentives for Participation in Advanced APMs

1. Changes to Terms, Definitions, and Regulatory Text

As most of these items relate to Qualifying Participant (QP) determinations, CMS begins by repring some background information:

- Eligible clinicians¹⁰ may become 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).¹¹
- A QP 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, QPs receive a lump sum bonus; starting in 2026, QPs receive a higher Physician Fee Schedule update for the year.¹²

¹⁰ MACRA includes physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, or a group of such clinicians, as eligible clinicians beginning with performance year 2017. The HHS Secretary may expand this list beginning with performance year 2019 (e.g., physical therapist).

¹¹ “Advanced APM” applies only when Medicare is the payer; the remainder are “Other Payer Advanced APMs”.

¹² 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.

CMS next addresses several terms and definitions, proposing the following:

- Replace the term “QP Performance Period” with two terms, as contextually appropriate, in QPP definitions and regulations. Use “All-Payer QP Performance Period” only under the All-Payer Combination Option, and use “Medicare QP Performance Period” under both the Medicare and All-Payer Combination Options. This change supports the proposed revised All-Payer QP performance period timeframe (Section II.D.6.d.(2)(a)).¹³
- Remove the term “Advanced APM Entity” and replace it throughout the regulations with “APM Entity” as well as in the definitions of “Affiliated Practitioner” and “Attributed Beneficiary”. Remove the term “Advanced APM Entity group” and replace it with “APM Entity group”.¹⁴
- Apply the definition of “Attributed Beneficiary” only to Advanced, not Other Payer Advanced, APMs. This change supports the proposal to make All-Payer Combination Option QP determinations only at the individual, not group, level (Section II.D.6.d.(3)(a)).
- Clarify in the definition of APM Entity that a non-Medicare payment arrangement is an Other Payer arrangement.
- Clarify that a “Medicaid APM” must meet all Other Payer Advanced APM criteria.
- Revise monitoring and program integrity provisions (§414.1460) to separate rescinding QP determinations from recouping APM incentive payments, and to consolidate APM incentive payment reduction and denial policies.
- Address typographical and regulation-sequencing errors.

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

CMS recalls that an Advanced APM must require its participating entities to bear financial risk for more than nominal monetary losses.¹⁵ CMS previously set distinct “generally applicable” and “Medical Home Model” standards for both financial risk-bearing and more than nominal amounts. Prior regulations also established separate benchmark-based (total cost of care) and revenue-based nominal amount standards for Advanced APMs under each of the generally applicable and medical home model categories. The two revenue-based standards are specified in terms of the “average estimated total Medicare Parts A and B revenue of participating APM Entities”.

Having considered public comments received about the revenue-based standards, CMS proposes the following regulatory amendments:

- Clarify that the standards refer to revenues received by all providers and suppliers in participating APM entities, not just those revenues paid directly to the entities.

¹³ Medicare QP Performance Period = January 1 - August 31; proposed All-Payer QP Performance Period = January 1 - June 30.

¹⁴ CMS perceives these changes as technical rather than substantive. Further modifications/rewording may be required for clarity; for example, in §414.1455 (a) Limitation on Review.

¹⁵ 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.

- For the 2019 and 2020 Medicare QP performance periods, the Advanced APM generally applicable revenue-based nominal amount standard will remain at 8 percent of the average estimated total Medicare Parts A and B revenues of all providers and suppliers in participating APM entities.
 - CMS will address the standard for 2021 and thereafter through future rulemaking.
- Progression of the medical home model Advanced APM standard will be adjusted to 2 percent for the 2018 Medicare QP performance period, 3 percent for 2019, 4 percent for 2020, and 5 percent for 2020 and later. The percentage applies to the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM entities.
- Beginning with the 2018 Medicare QP performance period, the medical home model revenue-based standard will be restricted for use to medical home APM entities with <50 eligible clinicians in their parent organizations.
 - CMS exempts from this requirement those entities enrolled in Round 1 of the Comprehensive Primary Care Plus (CPC+) model, since the size requirement was finalized after CPC+ participants signed agreements with CMS.
 - Future CPC+ participants (e.g., Round 2, now enrolling) would not be exempt.

3. QP and Partial QP Determination

(Note that since QP calculation results simultaneously allow Partial QP determinations, Partial QP processes are discussed separately below only when they differ from those for QP status).

CMS addresses two QP determination special situations. These occur when advanced APM start and end dates are not synchronized with the QP performance period and when an eligible clinician participates in multiple Advanced APMs during a single period. CMS notes having previously finalized the QP Performance Period as January 1 through August 31 annually. That period, if finalized as proposed, will renamed the “Medicare QP Performance Period”.

Advanced APM start and end dates are set by CMS and may differ from the dates for the Medicare QP Performance Period. Substituting full Medicare QP performance period data for the APM’s actual longer or shorter performance periods could penalize participating entities and clinicians in QP calculations. Therefore, CMS proposes to use data only from dates during which an entity could participate in the Advanced APM.¹⁶ Data from models in active testing for a period of less than 60 continuous days would not be included in QP calculations (except when an individual eligible clinician participates in multiple Advanced APMs).¹⁷ QP determinations would be made for each snapshot period during a year in which a model was actively tested for 60 or more continuous days. The three snapshot periods start annually on January 1 and end March 31, June 30, or August 31, respectively.

An eligible clinician may be part of multiple Advanced APM entity groups, no one of which achieves QP status. In this case the clinician’s data are summed and QP calculations include

¹⁶ 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.

¹⁷ 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. Active testing starts once any entity begins furnishing such services.

data from the entire Medicare QP performance period regardless of APM start or end dates. An individual clinician reaching QP status only through such calculation will lose QP status if any of the entities terminates from its Advanced APM before the performance period ends (August 31).

4. All-Payer Combination Option

a. Overview

For payment years 2019 and 2020, eligible clinicians can reach QP status only via the Medicare Option, by 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.¹⁸ Starting with payment year 2021, a clinician may alternatively achieve QP status through the All-Payer Combination Option. Thresholds under the All-Payer Option can be met by combining payments or patients from Other Payer Advanced APMs with those from Advanced APMs. CMS will assess QP status for each clinician under both options and will use the results most favorable to the clinician. Thresholds and determination decision trees for both options were published previously (81 FR 77460-77461) and reproduced in the proposed rule.¹⁹

b. Other Payer Advanced APM Criteria

(1) General Considerations

CMS notes that Medicare Health Plans²⁰ are considered Other Payers, as is any payer, public or private, other than fee-for-service Medicare. CMS recalls that an Other Payer Advanced APM must meet criteria for CEHRT use, MIPS-comparable quality measures, and financial risk to be considered an Other Payer Advanced APM. CMS observes that the All-Payer Option presents operational challenges compared to the Medicare Option. Under the latter, CMS has access to all information necessary to determine if an APM is an Advanced APM and if an eligible clinician's payments or patients meet QP status thresholds. Under the former, CMS must receive that information from an external source (e.g., clinician, APM entity, or payer; Section II.D.6.c.).

(2) Other Payer Medical Home Model

CMS perceives that medical homes operated by other payers may exist that could appropriately be considered medical home models under the All-Payer Option (e.g., CPC+ aligned medical homes). CMS offers, and **seeks comment upon**, an Other Payer Medical Home Model definition as an other payer arrangement determined by CMS to have a primary care focus,

¹⁸ Part B payment thresholds are set in statute while patient count thresholds are set by the Secretary.

¹⁹ 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.

²⁰ Medicare Health Plans include Medicare Advantage, Medicare-Medicaid Plans, section 1876 Cost Contract Plans, and section 1833 Health Care Prepayment Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) Plans.

empanel each patient to a primary clinician, and engage in advanced primary care activities.²¹ CMS anticipates that Other Payer medical home model participants could have limited ability to bear risk and should have special financial risk and nominal amount standards like those of the Medicaid Medical Home model. CMS also **seeks comment** whether any existing payment arrangements would meet this definition and whether they would meet the current generally applicable Other Payer Advanced APM financial risk and nominal amount standards. Finally, CMS **seeks comment** on any special considerations relevant to defining a medical home model standard for payers whose arrangements would not fit under the Medical Home or Medicaid Medical Home model definitions (including how a 50-clinician size cap might apply to a nominal amount standard).

(3) Other Payer Advanced APM Financial Risk Criteria

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 at least 3 percent of expected expenditures for which the APM Entity is responsible. This standard differs from the Advanced APM nominal risk standard of either 8 percent of average estimated Parts A and B revenues (revenue-based) or 3 percent of expected expenditures for which the APM Entity is responsible (benchmark-based). CMS explicitly states that it will retain the tripartite standard without modification but **seeks comment** on this and potential alternative approaches.

CMS proposes to add a revenue-based generally applicable nominal amount standard for the 2019 and 2020 All-Payer QP performance periods for 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 of the entity's participating providers and suppliers. For Advanced APMs whose risk is not explicitly defined in revenue terms, CMS can alternatively assess revenue-based risk using estimated average revenues of model participants. Lacking access to Other Payer claims and revenue data, CMS cannot make such an alternative assessment for Other Payer APMs. An Other Payer Advanced APM must satisfy either the revenue-based or the tripartite standard. CMS does not establish a revenue standard for the 2021 All-Payer QP Performance period or succeeding years.

Finally, CMS proposes to reduce the rate of progression of the nominal risk standard amount for Medicaid Medical Home models: for the 2019 All-Payer QP Performance period from 4 percent to 3 percent of the APM Entity's total revenue under the payer, and for the 2020 period from 5 percent to 4 percent. The risk would remain at 5 percent for the 2021 period and beyond. CMS believes that this progression better accounts for the inexperience with risk-bearing of most Medicaid medical homes.

²¹ Requires at least four of the following: chronic and preventive care coordination, patient access and continuity of care, risk-stratified care management, care coordination across the medical neighborhood, patient and caregiver engagement, shared decision-making, or arrangements beyond or substituting for fee-for-service payments.

c. Other Payer Advanced APM Determination Process

In this section CMS proposes two parallel determination processes, termed Payer Initiated and Eligible Clinician Initiated, for assessing whether specific payment arrangements outside of fee-for-service Medicare meet Other Payer Advanced APM criteria. The two processes have similar elements, but their timelines are distinct and some elements vary by payer type. General concepts for each process are considered first followed by specific provisions by payer type. (Tables 50-54 from the proposed rule, which summarize the processes, are combined and reproduced at the end of Section D in this summary.)

(1) Payer Initiated Other Payer Advanced APM Determination Process

For the Payer Initiated process, CMS begins by proposing the following:

- The process is voluntary and generally involves the same steps for all payer types.
- Other Payer Advanced APM determinations would 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 All-Payer performance period, and annually thereafter.
 - Medicare Health Plans include Medicare Advantage, Medicare-Medicaid Plans, section 1876 Cost Contract Plans, section 1833 Health Care Prepayment Plans, and Programs of All Inclusive Care for the Elderly (PACE) Plans.
 - The proposed All-Payer QP Performance Period would run January 1- June 30 annually. CMS believes determinations for the payers specified above could be completed before the performance period starts.
 - These payers may also concurrently request determinations for their commercial arrangements that follow the same payment arrangements as their Title XIX, Medicare Health Plan, or CMS Multi-Payer arrangement, respectively.
- 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.
 - CMS perceives that phasing in payer request start dates will allow the process to roll out more smoothly and facilitate later submissions.

For the Payer Initiated process, CMS proposes the following general workflow elements:

- Providing Payer Initiated process guidance for each payer type before the first submission period (period occurs in 2018);
- Making available a standard Payer Initiated Submission Form before the first submission period;²²
 - Use of the form is mandatory and a separate form is required for each other payer arrangement, as determinations are made separately. A multi-track payment arrangement may be submitted as a single request with specific information for all tracks; individual track determinations will be made.

²² CMS will seek OMB approval for the Payer Initiated and Eligible Clinician Initiated Submission forms and publish the required Paperwork Reduction Act notices. The entire information collection request and all related forms will be open for public review prior to OMB submission.

- 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 10 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.
- 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 performance period starts.
 - The list will be updated with other Eligible Clinician Initiated determination results after the associated All-Payer performance period ends.

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

CMS begins by noting that both APM entities and eligible clinicians may request determinations through the proposed Eligible Clinician Initiated process. The process does not distinguish between the two classes of requesters. Requests may be made after the All- Payer performance period closes (except for Title XIX payment arrangements, see below). The Eligible Clinician Initiated process is neither necessary nor applicable when a payment arrangement has already been determined to be an Other Payer Advanced APM through the Payer Initiated process.

For the Eligible Clinician Initiated process, CMS proposes the following general workflow elements (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 All-Payer QP Performance Period year* (except for Title XIX arrangement requests).
- Notifying the *requestor* when a form contains incomplete or inadequate information and allowing 10 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.
- 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 performance period starts.
 - The list will be updated with other Eligible Clinician Initiated determination results after the associated All-Payer performance period ends.

For the proposed Eligible Clinician Initiated process, CMS notes that when complete forms are submitted by September 1 of the relevant All-Payer performance period year, determinations may be finished and results shared with requestors before the December 1 QP determination submission deadline. Finally, CMS proposes that requestors may submit information about an Other Payer arrangement for a subsequent performance period even though CMS has determined that arrangement not to be an Other Payer Advanced APM for a prior year.

(3) Medicaid APMs and Medicaid Medical Home Models

CMS addresses considerations specific to the Other Payer Advanced APM determination process when Medicaid is a payer. Issues arise from statutory provisions to exclude Title XIX payments and patients from All-Payer Combination Option QP calculations whenever a state has no Medicaid APM or Medicaid Medical Home that meets Other Payer Advanced APM criteria, available to an eligible clinician. Inappropriate payment or patient exclusion could unfairly impact clinician QP determinations. To avoid this outcome, CMS proposes the following:

- To assess at the county level whether and where a state²³ 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;²⁴ 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).

CMS also proposes that states will serve in the payer role for the Payer Initiated 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 All-Payer 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).

²³ “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.

²⁴ If CMS receives no APM determination requests for a year through states, APM entities, or eligible clinicians, CMS would assume that no Medicaid Other Payer Advanced APMs are operating in the state during that year.

(4) CMS Multi-Payer Models

CMS addresses considerations specific to the Other Payer Advanced APM determination process for CMS Multi-Payer Models. Such a model is defined to be 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). The aligned other payer(s) may meet Other Payer Advanced APM criteria (or not) and may request a Payer Initiated determination from January 1 through June 30 of the year before the All-Payer performance period. When a Multi-Payer model agreement includes a state specifying uniform payment arrangements across state-based payers, the state would serve in the payer role (i.e., initiate the request on behalf of all payers and provide required information for all payers to CMS). When Medicaid is an aligned payer, however, the Other Payer Advanced APM determination must follow the Medicaid Payer Initiated Process described above. APM entities and eligible clinicians also may request aligned Other Payer determinations from August 1 through December 1 of the associated All-Payer QP performance period using the Eligible Clinician Initiated process.

(5) Medicare Health Plans

CMS believes that by statute only Medicare Part B payments and patients may be used in Medicare Option QP 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 payment year 2021. CMS acknowledges requests to create a participation credit pathway sooner under the Medicare Option. It is exploring opportunities to do so and **seeks comment** upon relevant approaches. Under the All-Payer Option, clinician participation in Medicare Health Plans meeting Other Payer Advanced APM criteria will receive credit consistent with the terms of the payment arrangement between the clinician and the health plan. Other Payer Advanced APM determinations may be requested by a Medicare Health Plan using the Payer Initiated process. CMS proposes that the annual submission period would be contemporaneous with the Medicare Advantage contract bidding process, starting when bid packages are sent out in April and ending with the bid submission deadline on the first Monday in June of the year preceding the relevant All-Payer performance period.²⁵ APM entities and eligible clinicians may request Other Payer Advanced APM determinations using the Eligible Clinician process from August 1 through December 1 of the associated All-Payer performance period. Complete requests submitted by September 1 may allow determinations to be made before December 1.

(6) Remaining Other Payers

CMS proposes to defer the Payer Initiated process for these payers (e.g., commercial, other private, and not addressed above) to start at some point prior to the 2020 All-Payer QP Performance Period. APM entities and eligible clinicians may request Other Payer Advanced

²⁵ 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.

APM determinations for arrangements with these payers from August 1 through December 1 of the associated All-Payer performance period.

(7) Information Submission for Other Payer Advanced APM Determinations

Required Information. CMS proposes that the requesting payers or APM entities/eligible clinicians provide, with each other payer arrangement determination request, the information listed in the table below.

Required Information Submission for Other Payer Advanced APM Determination		
Information Item	Payer Initiated	Eligible Clinician Initiated
Name of payment arrangement	X	X
Brief description nature of the arrangement	X	X
Term of the arrangement (anticipated start/end dates)	X	X
Participant eligibility criteria	X	X
Locations where arrangement will be available (county, state, national)	X	X
Evidence that CEHRT criterion is satisfied	X	X
Evidence that quality measure criterion is satisfied	X	X
Evidence that the financial risk criterion is satisfied	X	X
Other potentially necessary documentation needed for determination*	X	X

* For example, contracts, other governance documents, other payment-related documents

Certification and Program Integrity. For the Payer Initiated process, CMS proposes that a payer submitting information must certify to the best of its knowledge that the submitted information is true, accurate, and complete. Such certification would be sent with the Payer Initiated submission form. CMS further proposes that:

- Payer-submitted information may be audited.
- Payers must maintain all information needed (e.g., contracts) needed to enable an audit.
- Information must be maintained for 10 years after submission or audit completion.
- Information and supporting documentation must be provided upon request to CMS.

For the Eligible Clinician Initiated process, CMS proposes to remove the current requirement that payers attest to the accuracy of clinician-submitted information and to add a requirement that a submitting APM entity or eligible clinician must certify to the best of its knowledge that the submitted information is true, accurate, and complete. Certification would be sent with the Payer Initiated submission form. APM Entity-submitted information must be certified by an individual authorized to bind the APM Entity. CMS further proposes that:

- APM Entity or clinician-submitted information may be audited by CMS.
- Entities and clinicians must maintain all information needed (e.g., contracts, records) needed to enable an audit.
- Information must be maintained for 10 years after submission or audit completion.
- Information and supporting documentation must be provided upon request to CMS.

Outcome Measure. CMS clarifies the Other Payer Advanced APM quality-related criterion. To satisfy the criterion, a payer arrangement must include a MIPS-comparable outcome measure. When no applicable outcome measure is available, the payer, APM entity, or eligible clinician who is submitting Other Payer Advanced APM determination information, must certify that the MIPS quality measure list does not include an available or applicable outcome measure.

Use of Submitted Information. When posting the Other Payer Advanced APM list on the CMS website, CMS proposes to disclose only each payer's name along with the name and location for each of its Other Payer Advanced APMs. CMS proposes that all other information submitted through the Payer Initiated or Eligible Clinician Initiated processes would be kept confidential to the extent permitted by federal law to avoid exposing trade secrets or other sensitive information.

Use of CEHRT. Each Other Payer Advanced model must require that 50 percent or more of eligible clinicians participating in each APM Entity document and communicate clinical care using CEHRT. CMS believes that while clinicians will know and be able to document their individual CEHRT use, they may not have access to information that demonstrates CEHRT use by 50 percent of all clinicians in their entity. CMS proposes to presume that the 50 percent CEHRT criterion is being met by the Other Payer APM Entity if the individual clinician requesting the Other Payer Advanced APM determination can show that CEHRT use is required by the payment arrangement of the APM with the requesting physician.

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 year 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) then under the All-Payer Option (by both methods). CMS will apply the most advantageous of the calculation results for each clinician. Certain “excepted payments” are excluded from all calculations: Department of Defense, Veterans Administration, and Title XIX (for states lacking an available, applicable Medicaid APM or Medicaid Medical Home model, discussed above). 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

CMS previously defined a QP Performance Period, running annually from January 1 through August 31 two years prior to each payment year. CMS would use data from this time period for QP assessments. To facilitate implementation of the All-Payer Option, CMS now proposes to rename this time period the Medicare QP Performance Period and to create a separate All-Payer QP Performance Period of January 1 through June 30. CMS proposes to perform an All-Payer Combination Option QP determination upon request by an eligible clinician, but the clinician must submit payment and patient data with the request. Most eligible clinicians work with multiple (non-Medicare) payers whose data collection and claims processing systems are not

uniform. CMS anticipates that data acquisition, collation, and submission from all relevant payers will present substantive challenges to many eligible clinicians. CMS further anticipates that completing multiple QP determinations per clinician, using Medicare and Other Payer data quickly enough to provide QP status notifications to clinicians before they must otherwise submit data under MIPS, could operationally challenge CMS. CMS proposes to notify clinicians of their QP status results as soon as practicable after the proposed December 1 All-Payer QP Determination Submission Deadline. CMS believes that the proposed All-Payer period can be blended with the existing Medicare period to allow most clinicians to receive their QP status results early enough to allow subsequent submission of data to MIPS, if such submission is required should the clinician not achieve QP or Partial QP status. The proposed Other Payer period also permits 90 days for Other Payer claims run out plus 60 days thereafter for clinicians to prepare and submit data to CMS before the proposed December 1 QP determination submission deadline.

Relatedly, CMS also proposes to align the Medicare and All-Payer performance intervals used for All-Payer QP determinations. Lack of alignment would be undesirable, as it would comingle Medicare and Other Payer data from non-uniform time periods. CMS recalls that Medicare Option QP determinations will be made for three snapshot periods (ending March 31, June 30, and August 31; all begin January 1). CMS, therefore, would align Medicare snapshot data with the proposed All-Payer QP performance period data, so that All-Payer QP determinations will be made for the January-March and January-June intervals. (A Medicare Option only determination will also be made using January-August data from CMS.)

(2) QP Determination Level

With rare exceptions, Medicare Option QP determinations will be made at the APM Entity level (group rather than individual),²⁶ but CMS has reconsidered its decision to make All-Payer determinations at the same level. While clinicians participating in an Advanced APM Entity likely share a high level of involvement in the entity's cost and quality initiatives, CMS believes that clinician involvement and shared accountability in Other Payer Advanced APM Entities are more variable. Further, clinicians may participate in multiple Other Payer entities whose memberships are not likely to overlap consistently. Group data from Other Payer Advanced APMs are therefore less likely to capture most clinicians' participation accurately.

Based upon these concerns, CMS now proposes that All-Payer QP determinations be made at the individual clinician level.

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

Assuming that All-Payer QP determinations are made as proposed at the individual level, CMS voices reservations about combining that individual data with group-level Medicare payment and patient data when calculating an individual clinician's All-Payer QP threshold scores. Such data admixture would most often disproportionately underweight Other Payer activates in relation to the individual clinician's (Medicare) Advanced APM performance. CMS proposes to address

²⁶ Exceptions include clinicians on Affiliated Practitioner lists and clinicians who participate in multiple (Medicare) Advanced APMs, none of which achieve QP status.

this concern in two steps. First, when calculating the Medicare portion of an All-Payer Combination Option QP determination for an individual clinician, CMS would utilize the individual's (not the entity's) Medicare payment and patient data (thus aligning it with the individual Other Payer portion). Second, CMS would compare the clinician's (Medicare) QP threshold score with the entity's (group-level) threshold score. When a clinician's group-level threshold score is higher than the individual-level score, CMS proposes to apply a weighted methodology in recognition of the clinician's choice for APM entity participation. The APM entity's threshold score would be applied to the portion of the entity's payments or patients attributable to that clinician. The methodology multiplier formula is shown below and CMS describes some example calculations in the proposed rule (Section II.D.6.d.(3)(b)).

$$\text{(APM Entity Medicare Threshold Score} \times \text{Clinician Medicare Payments or Patients}) + \\ \text{(Individual Other Payer Advanced APM Payments or Patients)}$$

Individual Payments or Patients (All Payers except those excluded)

(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 proposes 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; 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.

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.

(5) Payment Amount Method

CMS proposes modifications to the All-Payer QP payment amount formula consistent with the proposal to make the QP determination at the individual level only, as described below.

Numerator: Aggregate of all payments from all payers (unless specified as excluded) attributable only to the eligible clinician, under the terms of all (Medicare) Advanced APMs and Other Payer Advanced APMs for the periods of either January-March or January-June during the All-Payer QP Performance Period

Denominator: Aggregate of all payments from all payers (unless specified as excluded) to the eligible clinician for the periods of either January-March or January-June during the All-Payer QP Performance Period

(6) Patient Count Method

CMS proposes modifications to the All-Payer QP patient count formula consistent with the proposal to make the QP determination at the individual level only, shown below.

Numerator: Number of unique patients to whom an eligible clinician furnishes services under the terms of all (Medicare) Advanced APMs and Other Payer Advanced APMs for the periods of either January-March or January-June during the All-Payer QP Performance Period

Denominator: Number of unique patients to whom an eligible clinician furnishes services under all payers for the periods of either January-March or January-June during the All-Payer QP Performance Period

(7) 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 proposes 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. (Only January-March data will be needed if the All-Payer QP performance period is finalized as January 1 – March 31. January-June data will be required if the All-Payer QP performance period is finalized as January 1 – August 31.) CMS proposes that all submitted clinician data be at the individual level, consistent with making only individual-level All-Payer determinations. CMS also proposes to allow APM entities to submit individual-level data on behalf of its individual clinicians. CMS additionally proposes that if an APM Entity or eligible clinician submits information sufficient only for the payment or the patient-count method calculations, 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 proposes to create a standard form for QP data submission by APM entities or eligible clinicians; use of the form would be mandatory.

Information Submission Deadline. CMS proposes that December 1 of the calendar year 2 years prior to the payment year will be used as the QP Determination Submission Deadline. (See Section II.D.6.d.(6) for related timelines). Prior to the deadline, CMS will evaluate submissions as received and notify submitters if the information is incomplete or inadequate; a 10-business day response and correction period is proposed. QP determinations will not be made unless sufficient information is submitted.

(8) Certification and Program Integrity

CMS proposes 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

determination request form. APM Entities and eligible clinicians who submit information must maintain all information needed (e.g., contracts, records) to enable an audit of the QP determination. Information must be maintained for 10 years after submission or audit completion, whichever occurs later, and information and supporting documentation must be provided upon request to CMS.

(9) Release of Submitted Information

To protect disclosure of trade secrets or potentially sensitive contractual material, CMS proposes to maintain confidentiality of all data and other information submitted by APM Entities or eligible clinicians related to All-Payer QP determinations, to the extent permissible under federal law.

(10) Examples

CMS provides and discusses examples illustrating the mechanics of All-Payer QP determination calculations by both the payment and patient count methods and using the proposed weighted methodology adjustment. (See Section II.D.6.d.(5) for complete details.)

(11) MIPS Reporting Election by Partial QPs

Medicare and All-Payer Option QP calculations also allow identification of clinicians achieving Partial QP status. Medicare Option Partial QPs may choose to be exempt from MIPS reporting for the associated performance period. CMS proposes that All-Payer Option Partial QPs would similarly make an election whether or not to be exempt from MIPS reporting and subject to MIPS payment adjustments.

From Tables 50-54. 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		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
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. Regulatory Impact Analysis

Overall Impact

CMS estimates that more than one-third of the nearly 1.5 million clinicians billing to Part B (572,299) will be assigned a MIPS score for 2020 because others will be ineligible for or excluded from MIPS. An estimated 585,560 clinicians would 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 2016, CMS estimates 74,920 qualifying APM participants (and thus excluded from MIPS) with associated incentive payment amounts that range from \$590 million to \$800 million.

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 86 and 87 summarize the average CMS estimated dollar impact of the proposed rule on physicians by specialty, and tables 88 and 89 summarize the impact by practice size. The first analysis, which CMS labels as “standard participation assumptions,” assumes that 90 percent of MIPS eligible clinicians participate, regardless of practice size (tables 86 and 88 using the “standard participation assumptions” are reproduced at the end of this document). The second analysis, which CMS labels as “alternative participation assumptions,” assumes a minimum participation rate of 80 percent.

Table 86: MIPS Estimated Payment Year 2020 Impact on Estimated Paid Amount by Specialty, Standard Participation Assumptions *

Provider Type, Specialty	Number of MIPS eligible clinicians	Estimated Paid Amount (mil) (80% of Allowed Charges) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians 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 Estimated Paid Amount
Overall	554,846	\$57,544	96.6%	96.1%	76.8%	3.9%	673.3	-173.3	0.9%
Addiction Medicine	71	\$3	95.8%	95.8%	82.4%	4.2%	0.0	0.0	-0.2%
Allergy/ Immunology	1,692	\$162	94.9%	94.9%	80.0%	5.1%	1.8	-0.8	0.6%
Anesthesiology	14,105	\$789	97.8%	95.7%	74.5%	4.3%	7.8	-3.0	0.6%
Anesthesiology Assistant	588	\$7	100.0%	99.8%	88.4%	0.2%	0.1	0.0	1.7%
Cardiac Electrophysiology	1,970	\$341	97.5%	98.4%	81.5%	1.6%	4.7	-0.4	1.3%
Cardiac Surgery	1,181	\$182	98.6%	98.3%	85.2%	1.7%	2.7	-0.2	1.4%
Cardiovascular Disease (Cardiology)	20,025	\$3,600	96.5%	96.8%	80.9%	3.2%	47.2	-8.5	1.1%
Certified Clinical Nurse Specialist	896	\$22	97.0%	96.4%	86.2%	3.6%	0.3	-0.2	0.4%
Certified Registered Nurse Anesthetist (CRNA)	16,600	\$259	99.3%	98.0%	84.7%	2.0%	3.1	-0.7	0.9%
Chiropractic	581	\$31	92.9%	92.6%	52.4%	7.4%	0.2	-0.2	-0.1%
Clinic or Group Practice	393	\$51	97.7%	97.2%	96.9%	2.8%	0.9	-0.4	1.0%
Colorectal Surgery (Proctology)	1,046	\$97	95.7%	96.2%	75.6%	3.8%	1.2	-0.3	0.9%
Critical Care (Intensivists)	2,730	\$201	97.0%	96.6%	82.9%	3.4%	2.5	-0.7	0.9%

Provider Type, Specialty	Number of MIPS eligible clinicians	Estimated Paid Amount (mil) (80% of Allowed Charges) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians 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 Estimated Paid Amount
Dermatology	9,506	\$2,510	91.8%	91.8%	69.6%	8.2%	27.2	-10.7	0.7%
Diagnostic Radiology	27,990	\$3,317	97.0%	95.7%	58.8%	4.3%	26.3	-6.8	0.6%
Emergency Medicine	31,503	\$1,728	99.1%	97.4%	56.2%	2.6%	12.8	-2.2	0.6%
Endocrinology	4,376	\$336	97.3%	97.2%	80.1%	2.8%	4.3	-1.0	1.0%
Family Medicine***	54,171	\$3,667	97.0%	96.9%	80.7%	3.1%	48.1	-11.1	1.0%
Gastroenterology	10,910	\$1,204	96.0%	96.5%	79.2%	3.5%	15.6	-2.8	1.1%
General Practice	2,210	\$214	91.3%	90.7%	74.7%	9.3%	1.9	-1.7	0.1%
General Surgery	14,135	\$1,143	96.6%	96.6%	79.4%	3.4%	13.9	-3.5	0.9%
Geriatric Medicine	1,394	\$121	96.4%	95.9%	77.0%	4.1%	1.4	-0.5	0.8%
Geriatric Psychiatry	119	\$9	91.6%	89.9%	76.6%	10.1%	0.1	-0.1	-0.7%
Gynecological Oncology	807	\$80	98.4%	98.3%	79.4%	1.7%	1.0	-0.1	1.0%
Hand Surgery	1,037	\$131	92.8%	92.3%	67.8%	7.7%	1.3	-0.5	0.6%
Hematology	648	\$109	98.6%	98.9%	83.5%	1.1%	1.5	0.0	1.4%
Hematology-Oncology	6,463	\$2,929	97.5%	97.2%	77.3%	2.8%	32.4	-4.5	1.0%
Hospice and Palliative Care	645	\$23	99.5%	99.1%	88.1%	0.9%	0.3	0.0	1.3%
Infectious Disease	4,571	\$497	94.2%	94.1%	78.9%	5.9%	5.6	-2.7	0.6%
Internal Medicine	72,692	\$6,917	95.9%	95.3%	80.0%	4.7%	86.1	-24.7	0.9%
Interventional Cardiology	2,716	\$491	97.5%	98.5%	83.8%	1.5%	7.1	-0.4	1.3%
Interventional Pain Management	1,255	\$333	90.0%	89.0%	62.8%	11.0%	3.2	-1.9	0.4%
Interventional Radiology	1,181	\$232	97.0%	96.1%	67.9%	3.9%	1.8	-0.5	0.6%

Provider Type, Specialty	Number of MIPS eligible clinicians	Estimated Paid Amount (mil) (80% of Allowed Charges) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians 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 Estimated Paid Amount
Maxillofacial Surgery	194	\$5	99.0%	99.0%	85.4%	1.0%	0.1	0.0	1.0%
Medical Oncology	2,530	\$870	98.5%	98.4%	78.2%	1.6%	9.3	-0.8	1.0%
Nephrology	5,707	\$1,073	95.1%	95.2%	78.2%	4.8%	12.9	-3.0	0.9%
Neurology	11,588	\$1,141	95.3%	95.7%	77.8%	4.3%	12.9	-5.4	0.7%
Neuropsychiatry	67	\$6	91.0%	91.0%	72.1%	9.0%	0.0	-0.1	-0.2%
Neurosurgery	3,850	\$505	95.3%	95.2%	72.9%	4.8%	5.5	-1.8	0.7%
Nuclear Medicine	466	\$66	97.0%	97.2%	81.2%	2.8%	0.7	-0.3	0.7%
Nurse Practitioner	50,649	\$1,313	98.0%	97.8%	87.3%	2.2%	16.7	-7.0	0.7%
Obstetrics & Gynecology	15,587	\$237	99.0%	99.1%	88.3%	0.9%	3.0	-0.6	1.0%
Ophthalmology	14,779	\$6,451	96.8%	96.6%	73.6%	3.4%	99.0	-5.9	1.4%
Optometry	4,621	\$439	94.5%	94.3%	69.2%	5.7%	5.0	-1.5	0.8%
Oral Surgery (Dentist only)	282	\$7	97.5%	97.9%	89.1%	2.1%	0.1	-0.1	-0.4%
Orthopedic Surgery	17,504	\$2,586	93.4%	93.3%	66.8%	6.7%	25.2	-9.9	0.6%
Osteopathic Manipulative Medicine	297	\$22	96.0%	94.9%	79.1%	5.1%	0.2	-0.1	0.7%
Otolaryngology	6,854	\$777	93.7%	92.5%	68.5%	7.5%	7.5	-3.6	0.5%
Pain Management	1,475	\$291	88.1%	86.6%	63.4%	13.4%	2.6	-2.0	0.2%
Pathology	7,924	\$770	96.6%	95.5%	65.0%	4.5%	6.1	-4.2	0.2%
Pediatric Medicine	4,007	\$43	99.6%	99.6%	90.2%	0.4%	0.5	-0.1	1.1%
Peripheral Vascular Disease	57	\$7	98.2%	96.5%	90.9%	3.5%	0.1	0.0	1.0%

Provider Type, Specialty	Number of MIPS eligible clinicians	Estimated Paid Amount (mil) (80% of Allowed Charges) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians 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 Estimated Paid Amount
Physical Medicine and Rehabilitation	5,237	\$734	91.3%	90.5%	68.4%	9.5%	6.4	-5.0	0.2%
Physician Assistant	38,378	\$875	98.7%	98.4%	84.1%	1.6%	11.2	-3.0	0.9%
Physician, Sleep Medicine	256	\$18	96.5%	97.7%	80.8%	2.3%	0.2	0.0	0.9%
Plastic/ Reconstructive Surgery	1,986	\$170	94.7%	94.7%	77.5%	5.3%	1.8	-1.0	0.4%
Podiatry	9,558	\$1,231	87.3%	87.0%	59.2%	13.0%	10.0	-9.1	0.1%
Preventive Medicine	221	\$11	98.2%	97.7%	83.8%	2.3%	0.1	0.0	0.8%
Psychiatry	10,590	\$487	93.9%	93.7%	75.2%	6.3%	4.2	-4.8	-0.1%
Pulmonary Disease	8,756	\$1,111	96.2%	96.2%	80.0%	3.8%	13.8	-3.4	0.9%
Radiation Oncology	3,049	\$810	97.9%	97.3%	80.8%	2.7%	9.0	-1.6	0.9%
Rheumatology	3,340	\$1,126	97.2%	97.2%	80.5%	2.8%	15.0	-2.0	1.2%
Sports Medicine	792	\$61	97.0%	96.8%	78.7%	3.2%	0.7	-0.1	0.9%
Surgical Oncology	713	\$52	98.6%	98.9%	82.7%	1.1%	0.7	-0.1	1.2%
Thoracic Surgery	1,738	\$203	97.8%	98.1%	82.9%	1.9%	2.8	-0.3	1.2%
Other	272	\$34	94.9%	95.6%	84.6%	4.4%	0.4	-0.1	0.9%
Urology	8,590	\$1,596	95.4%	96.1%	72.4%	3.9%	17.9	-3.4	0.9%
Vascular Surgery	2,725	\$683	95.8%	96.0%	73.9%	4.0%	7.5	-2.1	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 88: MIPS Estimated Payment Year 2020 Impact on Total Estimated Paid Amount by Practice Size, Standard Participation Assumptions *

Practice Size	Number of MIPS eligible clinicians	Estimated Paid Amount (mil) (80% of Allowed Charges) **	Percent eligible clinicians engaging with quality reporting	Percent Eligible Clinicians with Positive or Neutral Payment Adjustment	Percent Eligible Clinicians 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 Estimated Paid Amount
ALL PRACTICE SIZES	554,846	\$57,544	96.6%	96.1%	76.8%	3.9%	673.3	-173.3	0.9%
1-15 clinicians	114,424	\$26,091	90.0%	90.0%	64.2%	10.0%	288.2	-115.1	0.7%
16-24 clinicians	22,296	\$3,840	91.7%	89.1%	52.7%	10.9%	32.7	-17.9	0.4%
25-99 clinicians	99,285	\$9,814	96.2%	94.9%	63.7%	5.1%	94.3	-29.9	0.7%
100 or more clinicians	318,841	\$17,799	99.4%	99.2%	86.4%	0.8%	258.1	-10.4	1.4%

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