



Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models **[CMS-5517-FC]**

Summary of Final Rule

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I. Introduction and Background

On October 19, 2016 the Centers for Medicare & Medicaid Services (CMS) placed on public display a final rule with comment period establishing the Merit-based Incentive Payment System (MIPS) for MIPS eligible clinicians or groups under the Physician Fee Schedule (PFS) and

incentives for participation in certain alternative payment models (APMs).¹ Together, CMS refers to the MIPS and APM incentives as the Quality Payment Program (QPP). The rule is slated for publication in the November 4, 2016 issue of the *Federal Register*, and will take effect on January 1, 2017. While this is a final rule, CMS seeks comments on selected issues. **The 60-day comment period ends at close of business on December 19, 2016.**²

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) amended title XVIII of the Social Security Act (the Act) to repeal the sustainable growth rate, create a new pay-for-performance program for Medicare physician payment, and encourage physician participation in alternative payment models. MACRA provides for a 0.5 percent update for 2016 through 2019 under the PFS, and then zero percent updates for 2020 through 2025; after 2025 the update is 0.75 percent for qualifying APM participants, and 0.25 percent for others. Physicians' participation in MIPS or qualifying APMs largely determines their annual update in most years.

In this final rule, CMS establishes the MIPS and provides for the initial MIPS payment year of 2019 as a transition year. Standards are adopted for four performance categories: Quality, Advancing Care Information (ACI), Improvement Activities and Cost (referred to in the proposed rule as Resource Use). MIPS eligible clinicians are physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include these clinicians. The first performance period for MIPS will be 2017 and the first payment adjustments under MIPS will be made in 2019. (In this summary all references to years are calendar years unless otherwise noted.)

The table below, adapted from the CMS MACRA Quality Payment Program Fact Sheet, summarizes the key features of the MIPS for 2019 payment. Clinician performance on these components will determine their MIPS payment adjustment to Part B payments. Under MACRA, the percent payment adjustments can be positive or negative and range up to 4 percent for 2019, 5 percent for 2020, 7 percent for 2021 and 9 percent for 2022 and later years. For payment in 2019 through 2024, an additional positive adjustment is provided for exceptional performance. The fact sheet is available at: https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf.

¹ This summary uses the version of the final rule that CMS posted on their web site on October 14, 2016.

² Specific issues that CMS requests comments on are highlighted in bold font in this summary.

MIPS Performance Category	Requirements for 2019 Payment (2017 Performance)	Category Weight
Quality Replaces the Physician Quality Reporting Program (PQRS)	<u>Most participants</u> : Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days. <u>Groups using the web interface</u> : Report 15 quality measures for a full year. <u>Groups in APMs qualifying for special scoring under MIPS and are considered MIPS APMs</u> : Report quality measures through the APM. Groups do not need to do anything additional for MIPS quality.	60 Percent
Improvement Activities New Activity	<u>Most participants</u> : Attest to completing up to 4 improvement activities for a minimum of 90 days. <u>Groups with fewer than 15 participants or in a rural or health professional shortage area</u> : Attest to completing up to 2 improvement activities for a minimum of 90 days. <u>Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model</u> : Automatically earn full credit. <u>Groups in APMs qualifying for special scoring under MIPS and are considered MIPS APMs</u> : Automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit. <u>Participants in any other APM</u> : Automatically earn half credit and may report additional activities to increase score.	15 Percent
Advancing Care Information Replaces the Medicare EHR Incentive Program also known as Meaningful Use	Fulfill the required measures for a minimum of 90 days: • Security Risk Analysis • e-Prescribing • Provide Patient Access • Send Summary of Care • Request/Accept Summary of Care Choose to submit up to 9 measures for a minimum of 90 days for additional credit. OR Clinicians may not need to submit Advancing Care Information if these measures do not apply.	25 Percent
Cost Replaces the Value-Based Modifier	CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	0 percent (Will be counted starting in 2018)

Under the transition year requirements, clinicians will be permitted to submit only limited data for the 2017 performance year in order to avoid a negative payment adjustment in 2019. A final score of only 3 points totaled across the three categories that will be scored for 2019 will result in a neutral (zero percent) payment adjustment. A higher score may result in a positive adjustment, and a score of 70 points or more will be rewarded with an additional payment adjustment for exceptional performance.

CMS also adopts 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. The following APMs meet the advanced criteria to qualify for the bonus payment for performance year 2017 (payment year 2019): two-sided risk arrangements in the Medicare Shared Savings Program (Tracks 2 and 3), the Comprehensive Primary Care Plus (CPC+) model, and two-sided Oncology Care Model.³ CMS anticipates that in 2018 additional models will meet the Advanced APM criteria including a new ACO Track 1+ option, the Comprehensive Care for Joint Replacement Payment Model, and the Advancing Care Coordination through Episode Payment Models. Eligible clinicians considered QPs for a given performance year will receive a 5 percent incentive payment or bonus; those clinicians considered partial QPs will receive no bonus, but will not be subject to MIPS. This incentive payment is available during 2019 through 2024.

II. Provisions of the Final Regulations

A. Changes to Existing Programs

1. Sunsetting of Current Payment Adjustment Programs

Section 101(b) of the MACRA requires sunsetting of payment adjustments under the three existing programs for Medicare enrolled physicians and other practitioners: the Physician Quality Report System (PQRS), the Value-based Payment Modifier (VM), and the Medicare EHR Incentive Program.

For PQRS, CMS finalizes its proposal to amend the regulations to continue payment adjustments through 2018. For the VM, the program is already limited to certain years. For the Medicare EHR Incentive Program, CMS amends their regulations to remove references to the payment adjustment percentage for years after the 2018 payment year and add a terminal limit of the 2018 payment year.

2. Supporting Health Information Exchange and the Prevention of Health Information Blocking.

MACRA requires that to be a meaningful EHR user, an EP must demonstrate that they have not knowingly and willingly taken action (such as to disable functionality) to limit or restrict the compatibility of certified EHR technology. Similar requirements for eligible hospitals and CAHs. MACRA states that the demonstration requirements shall apply to meaningful EHR users as of the date that is 1 year after the date of enactment, which would be April 16, 2016.

CMS finalizes its proposal to revise the definition of a meaningful EHR user and the attestation requirements to provide that for attestations submitted on or after April 16, 2016 an EP, eligible hospital, or CAH under the Medicare and Medicaid EHR Incentive Programs must attest to a three-part attestation. CMS also finalizes its proposal to require such an attestation from all

³See https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf. This appears to be the final list, but in another section of its website CMS states that it anticipates these models will be Advanced APMs and will publish a final list before January 1, 2017.

eligible clinicians under the advancing care information performance category of MIPS, including eligible clinicians who report as part of an APM Entity group under the APM scoring standard.

The three-part attestation requirement for eligible clinicians, EPs, eligible hospitals and CAHs includes the following:

1. Attest that it did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of CEHRT.
2. Attest that it implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the CEHRT was, at all relevant times:
 - Connected in accordance with applicable law;
 - Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications and certification criteria adopted at 45 CFR part 170;
 - Implemented in a manner that allowed for timely access by patients to their electronic health information (including the ability to view, download, and transmit this information); and
 - Implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health providers, including unaffiliated providers and with disparate CEHRT and vendors.
3. Attest that it responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers, and other persons, regardless of the requestor's affiliation or technology vendor.

B. MIPS Program Details

1. MIPS Eligible Clinicians

a. Definition of a MIPS Eligible Clinician

CMS finalizes the following proposals:

- 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 professional.
- To exclude Qualifying APM Participants, Partial Qualifying APM participants who do not 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 finalizes its proposal to allow eligible clinicians who are not MIPS eligible professionals the option to voluntarily report measures and activities for MIPS. CMS finalizes that these clinicians who voluntarily report on applicable measures and activities specified under MIPS, will not receive an adjustment under MIPS.

b. Non-Patient Facing MIPS Eligible Clinicians

CMS finalizes with modifications its proposal to define a non-patient facing MIPS eligible clinician for MIPS as an individual MIPS eligible clinician or group that bills 25 or fewer patient-facing encounters during a performance period. Specifically, CMS finalizes the definition of a non-patient facing MIPS eligible clinician as:

- An individual MIPS eligible clinician that bills 100 or fewer patient facing encounters (including Medicare telehealth services defined in section 1834(m) of the Act) during the non-patient facing determination period, and
- A group providing more than 75 percent of the NPIs billing under the group's Tax Identification Number (TIN) meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period.

CMS intends to publish a list of patient-facing encounters on the CMS Web site located at [QualityPaymentProgram.cms.gov](https://www.cms.gov/QualityPaymentProgram).⁴

CMS establishes 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 will consist of 12 months.

- An initial 12-month segment will span 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 will allow 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 will span 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 will allow 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 2019 MIPS payment adjustment, 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, 2015 to August 31, 2016. The second determination period will be based on data starting from September 1, 2016 to August 31, 2017.

CMS modifies its definition of a patient-facing encounter and finalizes a patient-facing encounter as the evaluation and management services (the denominators for the cross-cutting measures) including Medicare telehealth services. CMS agrees with commenters who recommended that the definition of a non-patient facing MIPS eligible clinician should be based on the evaluation and management services and should not include other services, particularly 000 global codes. CMS does note, in response to a comment, that procedures such as peripheral nerve blocks (CPT

⁴ CMS needs to provide addition information about what is a patient-facing encounter. In response to comments, CMS provides conflicting information about the definition of patient-facing encounters.

codes 64400-64530) and epidural injections (CPT codes 62310-62319) will be included as patient-facing encounters. CMS intends to publish a list of patient-facing encounters on the CMS Web site located at [QualityPaymentProgram.cms.gov](https://www.cms.gov/QualityPaymentProgram).

CMS clarifies that its proposed definition of a non-patient facing MIPS eligible clinician did not include identification of any specific type of physician or clinical specialty.

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

MIPS eligible clinicians who practice in CAHs that bill under Method I (Method I CAHs) will 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 would 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. CMS also notes that for MIPS eligible clinicians who practice in Method II CAHs and have not assigned their billing rights to the CAH, the MIPS payment adjustment will apply to payments billed by the MIPS eligible clinicians under the PFS, but it will not apply to the facility payment to the CAH.

CMS finalizes its proposal that the MIPS payment adjustment will apply to Method II CAH payments when MIPS eligible clinicians who practice in Method II CAHs have assigned their billing rights to the CAH.

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

CMS finalizes its proposal that services performed by an 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.

e. Group Practice

CMS finalizes with modifications its proposed definition of a group and defines a group as a single TIN with two or more eligible clinicians (including at least one MIPS eligible clinician) as identified by their National Provider Identifiers (NPIs), who have assigned their Medicare billing rights to the TIN. CMS also finalizes to def an APM Entity group by a unique APM participant identifier.

2. MIPS Eligible Clinician Identifier

As discussed below, CMS finalizes its proposal to use multiple identifiers that allow MIPS eligible clinicians to be measured as an individual or through a group's performance and that the same identifier will be used across all four performance categories. CMS notes that it did not propose an identifier for virtual groups, but will take into consideration the establishment of a virtual group identifier.

Individual Identifiers. CMS finalizes its proposal to use a combination of billing TIN/NPI as the identifier to assess performance of an individual MIPS eligible clinician.

Similar to PQRS, each unique TIN/NPI combination will be considered a different eligible clinician, and MIPS performance would be assessed separately for each TIN under which an individual bills.

Group Identifiers for Performance. CMS finalizes its proposal to use a group's billing TIN to identify a group. CMS also finalizes with modifications its proposal to define 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.

CMS notes that a group must meet the definition of a group at all times during the performance period for the MIPS payment year in order to have its performance assessed as a group. In addition, a group that elects to have its performance assessed as a group will be assessed as a group across all four MIPS performance categories.

APM Entity Group Identifier for Performance. CMS finalizes its proposal 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 finalizes its proposal to define an APM Entity group as an APM Entity identified by a unique APM Participant identifier. CMS notes that the APM Entity identifiers are the same identifiers that are currently used by CMS for other purposes.

The MIPS payment adjustment for individual MIPS eligible clinicians is applied to the Medicare Part B payments for items and services furnished by each MIPS eligible clinician. For groups reporting at the group level, scoring and the application of the MIPS payment adjustment is applied at the TIN level for Medicare Part B payments for items and services furnished by the eligible clinicians of the group.

3. Exclusions

a. New Medicare-Enrolled Eligible Clinician

CMS finalizes its proposal that a new Medicare-enrolled eligible clinician is defined 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 finalizes in no case would a MIPS payment adjustment factor apply to items and services provided by new Medicare-enrolled eligible clinicians.

New Medicare-enrolled eligible clinicians will not be treated as MIPS eligible clinicians until the subsequent year and the performance period for such subsequent year.

CMS intends to conduct eligibility determinations on a quarterly basis to the extent it is technically feasible in order to identify new Medicare-enrolled eligible clinicians who would be excluded from the requirement to participate in MIPS for an applicable performance period.

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

CMS finalizes its proposal that the definition of a MIPS eligible clinician does not include QPs and Partial QPs who do not report on applicable measures and activities that are required to be reported under MIPS for any given performance period. Partial QPs will have the option to elect whether or not to report under MIPS, which determines whether or not they will be subject to MIPS payment adjustments.

c. Low-Volume Threshold

CMS defines a Medicare eligible clinician or group who does 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 \$30,000 or provides care for 100 or fewer Part B-enrolled Medicare beneficiaries. CMS finalizes the low-volume threshold also applies to MIPS eligible clinicians who practice in APMs under the APM scoring standard at the APM Entity level; APM Entities that do not exceed the low-volume threshold will be excluded from the MIPS requirements and will not be subject to a MIPS payment adjustment. This exclusion, however, will not affect an APM Entity's QP determination if the APM Entity is an Advanced APM.

CMS defines the low-volume threshold determination period as a 24-month assessment period, which includes a two-segment analysis of claims data during an initial 12-month period prior to the performance period followed by another 12-month period during the performance period.

- The initial determination period will span the last 4 months of the 2 years prior to the performance period followed by the first 8 months of the next calendar year and include a 60-day claims run out. This time frame will allow CMS to inform MIPS eligible clinicians and groups their low-volume status in December prior to the start of the performance period.
- A second 12-month segment of the low-volume threshold determination period will span from the last 4 months of the year prior to the performance period followed by the first 8 months of the performance period in the next year and include a 60-day claims run out. This time frame will allow CMS to inform additional eligible clinicians and groups of their low-volume status during the performance period.

CMS states it will not change the low-volume status of any individual MIPS eligible clinician or group identified during the first eligibility determination analysis based on the second eligibility determination analysis.

For the 2019 MIPS payment adjustment, CMS will initially identify the low-volume status of individual eligible clinicians based on 12 months of data starting from September 1, 2015 to August 31, 2016. The second determination period will be based on data starting from September 1, 2016 to August 31, 2017. CMS notes that the low-volume threshold determination period may apply to an eligible clinician who became a new Medicare-enrolled eligible clinician during the last 4 months of the year since this time period will be included in the initial determination period. The low-volume threshold determination may also apply to part-time MIPS eligible clinicians.

Eligible clinicians who are excluded from the definition of a MIPS eligible clinician under the low-volume threshold or another applicable exclusion can still participate voluntarily in MIPS, but are not subject to the MIPS payment adjustment.

d. Group Reporting

A group must meet the definition of a group at all times during the performance period. Further, in order to have 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.

A group deciding to submit data at the group level will have its performance assessed and scored across the TIN, which could include items and services furnished by individual NPIs within the TIN who are not required to participate in MIPS. Excluded eligible clinicians (new Medicare-enrolled, QPs or Partial QPs who do not report on applicable MIPS measures and activities, and do not exceed the low-volume threshold) are part of the group and are considered in the group's score. The MIPS payment adjustment will only apply to the Medicare Part B allowed charges pertaining to the group's MIPS eligible clinicians and not apply to clinicians excluded from MIPS.

Group reporting may include individual clinicians who do not meet the definition of a MIPS eligible clinician and are not required to participate in MIPS, but may voluntarily report measures and activities. Group reporting may voluntarily include such eligible clinicians in its aggregated data reported for measures and activities under MIPS. CMS states that for groups that voluntarily include eligible clinicians who do not meet the definition of a MIPS eligible clinician, they will have their performance assessed and scored across the TIN, but these clinicians will not receive a MIPS payment adjustment.

Requirements.

CMS finalizes its proposal to require a group to adhere to an election process established and required by CMS (§414.1310(e)(5)) including:

- Groups will not be required to register to have their performance assessed as a group except for groups submitting data on performance measures via the CMS Web Interface or groups electing to report the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey for the quality performance category.
- Groups electing participation via the CMS Web Interface or administration of the CAHPS survey must register by June 30 of the applicable 12-month performance period (i.e., June 30, 2017 for performance periods occurring in 2017).

4. Performance Period

CMS finalizes a modification of its proposal for the 12-month performance period for 2017:

- For purposes of the 2019 MIPS payment year, for all performance categories and submission mechanisms except for the cost performance category and data for the quality performance category reported through the CMS Web Interface, for the CAHPS MIPS survey, and for the all-cause hospital readmission measure, the performance period under MIPS is a minimum continuous 90-day period within 2017 (January 1, 2017 through December 31, 2017).
- The 90-day period can occur anytime MIPS Category within 2017 and MIPS eligible clinicians may utilize a different 90-day period for each performance category. CMS notes that the last date that the continuous 90-day period of time required for reporting in 2017 is October 2, 2017.
- The continuous 90-day period is a minimum. MIPS eligible clinicians may elect to report data on more than a continuous 90-day period, including a period of up to the full 12 months of 2017.

A 12-month period is needed for groups that elect to utilize the CMS Web Interface or report the CAHPS for MIPS survey because these mechanisms utilize certain assignments and sampling methodologies that are based on a 12-month period. In addition, administrative claims-based measures (including all of the cost measures and the all-cause readmission measure) are based on attributed populations using the 12-month performance period.

CMS also notes that for 2017, in order to avoid a negative MIPS payment adjustment, a MIPS eligible clinician may submit data for a period of less than 90 days (discussed below in section).

CMS finalizes the following for the 2020 MIPS payment year:

- The performance period for the quality and cost performance categories is 2018 (January 1, 2018 through December 31, 2018).
- The performance period for the improvement activities and advancing care information (ACI) performance categories is a minimum of a continuous 90-day period within 2018, up to and including the entire 2018 calendar year.

CMS modifies its proposal and finalizes it will use claims with dates of service during the performance period that must be processed no later than 60 days following the close of the performance period for purposes of assessing performance and computing the MIPS payment adjustment.

For individual MIPS eligible clinicians and group practices with less than 12 months of performance data to report, CMS finalizes its proposal that individual MIPS eligible clinicians or groups who report less than 12 months of data will be required to report all performance data available from the applicable performance period (e.g., to any 90-day period). CMS states it does not intend to make any scoring adjustments based on the duration of the performance period.

5. MIPS Category Measures and Reporting

a. Performance Category Measures and Reporting

Submission Mechanisms

CMS is finalizing all proposed data submissions mechanisms except it is not finalizing the data submission mechanism of administrative claims for the improvement activities performance category because it is not technically feasible at this time. The final data submission mechanisms are outlined in Table 3 and Table 4 in the final rule and reproduced below. CMS also finalizes its proposal that, except for groups that elect to report the CAHPS for MIPS survey, MIPS eligible clinicians and groups may elect to submit information via multiple mechanisms. CMS notes that for submission, eligible clinicians and groups must use the same identifier for all performance categories, and they may only use one submission mechanism per performance category. For individual clinicians and groups that are not MIPS eligible clinicians but elect to report to MIPS, CMS will calculate administrative claims cost measures and quality measures, if data are available.

CMS also finalizes the following definitions as proposed:

- Attestation means a secure mechanism, specified by CMS, with respect to a particular performance period, whereby a MIPS eligible clinician or group may submit the required data for advancing care information or the improvement activities performance categories in a manner specified by CMS;
- CMS-approved survey vendor means a survey vendor that is approved by CMS for a particular performance period to administer the CAHPS for MIPS survey and to transmit survey measures data to CMS; and
- CMS Web Interface means a web product developed by CMS that is used by groups that have elected to utilize the CMS Web Interface to submit data on the MIPS measures and activities.

TABLE 3: 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 4: Data Submission Mechanisms for Groups

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) 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)

CMS clarifies the difference between “claims” and “administrative claims” as reporting mechanisms. CMS notes that the claims submission mechanism refers to specific quality measures that require MIPS eligible clinicians to append certain billing codes to indicate to CMS the required quality action or exclusion occurred. The administrative claims submission mechanism is used for specific quality measures and the cost performance category and requires

no separate data submission to CMS. CMS calculates these measures based on data available from MIPS eligible clinicians' billings on Medicare Part B claims.

Submission Deadlines

CMS finalizes the following related to the submission deadlines:

- The data submission deadline for the qualified registry, QCDR, EHR, and attestation submission mechanisms will be March 31 following the close of the performance period. The final deadline for 2017 performance period will be March 31, 2018.
- The submission period will begin prior to January 2 following the close of the performance period, if technically feasible. For example, for the first MIPS performance period, the data submission period will occur prior to January 2, 2018, through March 31, 2018, 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.
- For the Medicare Part B claims submission mechanism, the submission deadline will occur during the performance period and will be required to be processed no later than 60 days following the close of the performance period.
- For the CMS Web Interface submission mechanism, the submission deadline will occur during an 8-week period following the close of the performance period that will begin no earlier than January 1 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

MACRA states the quality performance category will account for 30 percent of the final score. However, the Act stipulates that for the first and second years of MIPS, the percentage of the final score applicable for the quality performance category will be increased so that the total percentage points of the increase equals the total number of percentage points by which the percentage applied for the cost performance category is less than 30 percent. For the first year, not more than 10 percent of the final score will be based on the cost category and for the second year, not more than 15 percent of the final score will be based on the cost category.

CMS finalizes the cost performance category will account for 0 percent of the final score in 2019, 10 percent of the final score in 2020 and 30 percent of the final score in 2021 and future MIPS payment years CMS is redistributing the final score weight from the cost performance category to the quality performance category. For the quality performance contribution to the final score, CMS finalizes:

- A quality performance weight of 60 percent for MIPS payment year 2019 and 50 percent for 2020; and

- A quality performance weight of 30 percent for the third and future payment years of the MIPS program.

(2) Quality Data Submission Criteria

The finalized quality data submission criteria for the 2019 MIPS payment year are summarized in Table 5 in the final rule and reproduced below at the end of this section.

Submission Criteria for Quality Measures Excluding CMS Web Interface and CAHPS for MIPS
For submission measures, excluding the CMS Web Interface and CAHPS, after consideration of comments, CMS finalizes its proposals with modifications:

- For the applicable performance period in 2017, the MIPS eligible clinician or group will report at least six measures including at least one outcome measure.
 - If an applicable measure is not available, CMS finalizes the requirement to report one other high priority measure that the eligible clinician or group will need to choose: appropriate use, patient safety, efficiency, patient experience, or care coordination measures.
 - If fewer than six measures apply, then CMS finalizes the requirement to report on each measure that is applicable.
- Alternatively, for the applicable performance period in 2017, 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 list of all MIPS measures in Table A of the Appendix or a set of specialty-specific or subspecialty-specific measures in Table E of the Appendix. High priority measures are identified in Table A.

CMS is not finalizing its proposal to require MIPS eligible clinicians and groups to report a cross-cutting measure because it believes it should provide flexibility during the 2017 transition year.

CMS notes that certain improvement activities may count for bonus points in the advancing care information category if the MIPS eligible clinician uses CEHRT.

The 2017 performance period has a modified scoring approach, which ensures that MIPS eligible clinicians who only submit data on one measure avoid a negative MIPS adjustment. In the rare instances when providers submit quality measures through multiple mechanisms, CMS will score

all the options (such as scoring the quality performance with data from a registry and also score the quality performance with data from claims) and use the highest performance category score for the MIPS eligible clinician final score. CMS will not combine the submission mechanisms to calculate an aggregated performance score. Further, if more than six measures are submitted, CMS will score all measures and use the six that have the highest performance score.

Groups Reporting via the CMS Web Interface.

CMS finalizes its proposals for submission criteria for quality measures for groups reporting via the CMS Web Interface for the 12-month performance period:

- 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.
- If a group has no assigned patients, then the group, or individual MIPS eligible clinicians within the group, will need to select another mechanism to submit data to MIPS.

CMS also finalizes its proposal to continue to align the 2019 CMS Web Interface beneficiary assignment methodology with the measures that were in the VM.

The CAHPS for MIPS survey is available for all MIPS groups.

Groups Electing to Report CAHPS for MIPS Survey.

CMS finalizes its proposal to allow registered groups to voluntarily elect to participate in the CAHPS for MIPS survey. The group must have the survey reported on its behalf by a CMS-approved survey vendor. In addition, the group will need to use another submission mechanism to complete its quality data submission. The survey will count as a measure in the quality performance category and also will fulfill the requirement to report at least one high priority measure in the absence of an applicable outcome measure. The group will be required to submit at least five other measures through one other data submission mechanism.

CMS finalizes its proposal to retain the same survey administration period used for the PQRS survey (i.e., November to February of the reporting year); the administration will contain a six-month look-back period. Similar to the PQRS survey, groups that voluntarily elect to participate in the survey will bear the cost of contracting with a CMS-approved survey vendor to administer the CAHPS for MIPS survey. Only Medicare beneficiaries can be selected to participate in the survey.

The CAHPS for MIPS survey is optional for MIPS eligible groups.

Data Completeness Criteria.

CMS is finalizing 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. For 2017, MIPS eligible clinicians whose measures fall below the data completeness threshold of 50 percent will receive 3 points for submitting the measure.
- 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. For 2017, MIPS eligible clinicians whose measures fall below the data completeness threshold of 50 percent will receive 3 points for submitting the measure.
- 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 finalizes 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 notes that data completeness thresholds for data submitted on quality measures will increase for performance periods occurring in 2019 and onward.

While CMS is reducing the quality reporting thresholds to 50 percent for CY 2017 (payment year 2019), it does state that it believes it is providing ample notice to MIPS eligible clinicians so they can take the necessary steps to prepare for higher quality thresholds. CMS will continue to target a 90 percent reporting requirement as MIPS eligible clinicians gain experience with the MIPS, and it plans to further increase these thresholds over time.

Table 5: Summary of Final Quality Data Submission Criteria for MIPS Payment Year 2019 via Part B Claims, QCDR, Qualified Registry, EHR, CMS Web Interface, and CAHPS for MIPS Survey

Performance Period	Measure Type	Submission Mechanism	Submission Criteria	Data Completeness
A minimum of one continuous 90-day period during 2017	Individual MIPS eligible clinicians	Part B Claims	Report at least six measures including one outcome measure. • 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. Measures will have to be selected from all MIPS Measures (Table A) or a set of specialty-specific measures (Table E).	50 percent of MIPS eligible clinician's Medicare Part B patients for the performance period.
A minimum of one continuous 90-day period during 2017	Individual MIPS eligible clinicians or Groups	QCDR Qualified Registry EHR	Report at least six measures including one outcome measure. • 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. Measures will have to be selected from all MIPS Measures (Table A) or a set of specialty-specific measures (Table E).	50 percent of MIPS eligible clinician's or group's patients across all payers for the performance period.
January 1 – December 31	Groups	CMS Web Interface	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. • If the pool of eligible assigned beneficiaries is less than 248, then the group would report on 100 percent of assigned beneficiaries.	Sampling requirements for their Medicare Part B patients
January 1 – December 31	Groups	CAHPS for MIPS Survey	CMS-approved survey vendor would have to be paired with another reporting mechanism to ensure the minimum number of measures is reported. • 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 their Medicare Part B patients

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

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.

(4) Application of Additional System Measures

CMS continues to consider an option for facility-based MIPS eligible clinicians to elect to use their institution's performance rates as a proxy for the MIPS eligible clinician's quality score. It is not proposing an option for 2017 because of several operational considerations that need to be addressed before this option can be implemented.

(5) Global and Population-Based Measures

CMS is not finalizing its proposal to use the acute and chronic composite measures of AHRQ Prevention Quality Indicators (PQIs).

CMS is finalizing with modification the all-cause hospital readmission measure (ACR) from the VM as part of the quality measure domain for the MIPS total performance score.

- CMS will not apply the ACR measure to solo practices or small groups (groups defined as practices of 15 or fewer clinicians or solo practitioners).
- CMS will apply the ACR measure to groups of 16 or more who meet the case volume of 200 cases.

A group would be scored on the ACR measure even if it did not submit any quality measures. In 2017, the readmission measure alone will 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 to one of the three performance categories. CMS states that the ACR measure is not applicable to MIPS eligible clinicians who do not meet the minimum case requirements.

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

(1) Annual List of Quality Measures Available for MIPS Assessment

CMS corrects, revises specific information, and finalizes the quality measures for MIPS reporting in 2017 in Appendix A to this final rule.

Appendix A⁵ includes the following tables:

- Table A: Final Individual Quality Measures Available for MIPS Reporting in 2017
- Table B: Quality Measures That Are Calculated for 2017 MIPS Performance That Do Not Require Data Submission

⁵ Table C: Individual Quality Cross-Cutting Measures for the MIPS to Be Available to Meet the Reporting Criteria Via Claims, Registry, and EHR Beginning in 2017 has been removed because the requirement to report a cross-cutting measure was not finalized for MIPS reporting in 2017.

- Table D: Finalized New Measures for MIPS Reporting in 2017
- Table E: Finalized MIPS Specialty Measure Sets
 - The specialty measure sets are the same measures included in Table A but are sorted consistent with the American Board of Medical Specialties (ABMS) specialties.
- Table F: 2016 PQRS Measures Finalized for Removal for MIPS Reporting in 2017
- Table G: Measures Finalized with Substantive Changes for MIPS Reporting in 2017
- Table H: Finalized Improvement Activities Inventory

CMS plans to make annual updates to the list of quality measures through future notice and comment rulemaking but cannot provide more specificity on the rulemaking schedule. CMS intends to post the measures and their specifications on the QPP website. CMS will publish the numerical baseline period benchmarks prior to the performance period (or as close to the start of the performance period as possible) in the same location as the detailed measure specifications.

CMS states it will release specifications for eQCMs well in advance of November 1.

(2) Cross-Cutting Measures for 2017 and Beyond

CMS is not finalizing the set of cross-cutting measures and the requirements related to reporting as proposed. Instead, the cross-cutting measures are incorporated into the MIPS individual and specialty measure sets within the appendix to this final rule.

d. Cost Performance Category

CMS finalizes the following cost performance category weights for the final score for the 2017 transition year (MIPS payment year 2019) and succeeding years:

MIPS Performance Period Year	MIPS Payment Year	Weight
2017	2019	0 Percent
2018	2020	10 Percent
2019 and succeeding years	2021 and succeeding years	30 Percent

The cost measures for the 2017 performance period will incorporate measures included in the VM or the 2014 Supplemental Quality and Resource Use Reports (sQRUR). CMS plans to continue developing care episode groups, patient condition groups, and patient relationship categories and it plans to incorporate new measures through future notice and comment rulemaking.

(1) Cost Criteria

Performance in the cost category will be assessed using measures based on administrative Medicare claims data. MIPS eligible clinicians and groups would be assessed based on cost only for Medicare patients attributed to them; MIPS eligible clinicians and groups would not be measured on cost if there are not enough attributed cases to meet or exceed the proposed case minimums.

For the 2017 MIPS performance period, CMS finalizes the use of:

- The total per capita cost measure,
- The MSPB measure, and
- Episode-based measures.

(a) Value Modifier Cost Measures for the MIPS Cost Performance Category

CMS will include the total per capita cost measure and the MSPB measure within the MIPS cost category for the 2017 performance period. For both the total per capita cost measure and the MSPB measure, CMS finalizes using the same methodologies for payment standardization and risk adjustment as are defined in the VM (for more details see 77 FR 69316 – 69318). As discussed below in this section, CMS finalizes one technical change to the MSPB calculation for the MIPS.

(i) Attribution. For the MSPB measure, CMS finalizes its proposal to use attribution logic that is similar to what is used in the VM. 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). For MIPS, CMS finalizes its proposal to make the following changes to the primary care services definition:

- Include transitional care management codes (99495 and 99496) and the chronic care management code (99490), and
- Exclude services billed under HCPCS codes 99304 – 99318 when the claim includes the POS 31 modifier (patients in skilled nursing facilities).

(ii) Reliability. For the total per capita cost measure, CMS finalizes its proposal to use a minimum of 20 cases, the same case minimum that is used for the VM.

For the MSPB measure, CMS is finalizing the two proposed two modifications to the methodology used in the VM. First, CMS removes the specialty adjustment from the MSPB measure's calculation. For the VM, the MSPB measure is risk adjusted to ensure that comparisons account for case-mix differences between practitioners' patient populations and the national average.

The second change CMS modifies the cost ratio used within the MSPB equation to evaluate the differences between observed and expected episode costs at the episode level before making a comparison at the individual or group level. Specifically, instead of summing all of the observed costs and dividing by the sum of all the expected costs, CMS will calculate the observed to expected cost ratio for each MSPB episode assigned to the MIPS eligible clinician

or group and then take the average of the assigned ratios. CMS will still take the calculated average and multiply it by the average of observed costs across all episodes nationally. CMS is finalizes a minimum case volume of 35 cases.

(b) Episode-based Measures for the MIPS Cost Performance Category

CMS finalizes 10 episode-based measures: Mastectomy, Aortic/Mitral Valve Surgery, Coronary Artery Bypass Graft (CABG), Hip/Femur Fracture or Dislocation Treatment (Inpatient-Based), Cholecystectomy and Common Duct Exploration, Colonoscopy and Biopsy, Transurethral Resection of the Prostate (TURP) for Benign Prostatic Hyperplasia, Lens and Cataract Procedures, Hip Replacement or Repair, and Knee Arthroplasty (Replacement). All of these measures were included in the sQRUR and meet the reliability threshold of 0.4 for the majority of clinicians and groups at a case minimum of 20. Table 7, in the final rule, includes detailed information about these 10 measures. For informational purposes, CMS intends to provide feedback to MIPS eligible clinicians on additional episode-based measures, which may be introduced in future years.

(i) Attribution. CMS finalizes its proposal to use the attribution logic used in the 2014 sQRUR with modifications to adjust for whether the performance is assessed at an individual or group level. (A full description is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Detailed-Mthods-2014SupplementalQRURs.pdf>.)

CMS finalizes acute condition episodes will be attributed to all MIPS eligible clinicians that bill at least 30 percent of inpatient evaluation and management (IP E&M) visits during the initial treatment or “trigger event” that opens the episode. Using this methodology, CMS notes it is possible that more than one MIPS eligible clinician will be attributed to a single episode. If an acute condition episode has no IP E&M claims during the episode, then that episode will not be attributed to any MIPS eligible clinician.

CMS finalizes procedural episodes will be attributed to all MIPS eligible clinicians that bill a Part B claim with a trigger code during the trigger event of the episode.

- For inpatient procedural episodes, the trigger event is defined as the IP stay that triggered the episode plus the day before the admission to the IP hospital.
- For outpatient procedural episodes developed using Method A, the trigger event is defined as the day of the triggering claim plus the day before and two days after the trigger event.
- For outpatient procedural episodes developed using Method B, the trigger event is defined as only the day of the triggering event.

CMS finalizes any Part B claim or line item during the trigger event with the episode’s triggering procedure code is used for attribution. If more than one eligible clinician bills a triggering claim, the episode is attributed to each of the eligible clinicians. If co-surgeons bill the triggering claim, the episode is attributed to each MIPS eligible clinician. If only an assistant surgeon bills the triggering claim, the episode is attributed to the assistant surgeon or the group. If an episode

does not have a concurrent Part B claim with a trigger code for the episode, then the episode is not attributed to any eligible clinician.

(c) Attribution for Individual and Groups

CMS will attribute cost measures for all clinicians at the TIN/NPI level. CMS provides an example in which a TIN had one surgeon that billed for 11 codes and another surgeon in the TIN that billed for 12 codes that would trigger the knee arthroplasty episode-based measure, and would not have enough cases to be measured individually. However, if the TIN elects group reporting the TIN would be assessed on the 23 combined cases.

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

For the 2017 MIPS performance period, CMS finalizes its proposal not to have any alternative cost measures for non-patient facing MIPS eligible clinicians or groups. Similar to eligible clinicians or groups that do not meet the required case minimum for any resource measures, many non-patient facing eligible clinicians may not have sufficient measures available to report.

(2) Future Modifications to Cost Performance Category

CMS states it intends to incorporate Part D costs into the cost performance category. CMS acknowledges the technical challenge in assessing the cost of drugs for all patients but notes it will continue to investigate methods to incorporate this spending into future cost measures.

e. Improvement Activities Category

(1) Contribution to Final Performance Score

The improvement activity performance will account for 15 percent of the final performance score.

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. CMS finalizes a MIPS eligible clinician or group is a certified-PCMH or comparable specialty practice if they have achieved certification or accreditation from:

- A national program,
- A regional or state program,
- A private payer, or
- Another body that certifies at least 500 or more practices for PCMH accreditation or comparable specialty practice certification.

Examples of nationally recognized accredited PCMH are the Accreditation Association for Ambulatory Health Care, the National Committee for Quality Assurance (NCQA) PCMH, the Joint Commission Designation or the Utilization Review Accreditation Commission (URAC).

CMS also finalizes the criteria for being a nationally recognized accredited PCMH are that it must be national in scope and must have evidence of being used by a large number of medical organizations as the model for their PCMH.

CMS will provide full credit for the improvement activity performance category for a MIPS eligible clinician or group that has received certification or accreditation as a PCMH or comparable specialty practice from a PCMI accreditation or comparable specialty practice certification program.

(2) Improvement Activities Data Submission Criteria

CMS finalizes data for the improvement activities performance category can be submitted using the qualified registry, EHR, QCDR, CMS Web Interface, and attestation data submission mechanisms (Tables 3 and 4 of the final rule) . CMS is not finalizing the data submission method of administrative claims as it is not technically feasible at this time. CMS also finalizes, except for MIPS APMs, all MIPS eligible clinicians or groups must select activities from the improvement activities inventory (Table H of the Appendix).

CMS finalizes its proposal 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.

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 is performing the activity for a continuous 90 days in the performance period, the group may report on that activity. The improvement activity inventory in Table H of the Appendix also includes a description of the specifications for how to satisfy the qualifications for each activity. All of the requirements of an activity must be met to receive credit for that activity; partial satisfaction of an activity is not sufficient to receive credit.

CMS will provide technical assistance through subregulatory guidance to further explain how to report on activities. This guidance will also include how to identify a specific activity through some type of numbering. CMS clarifies that the vendor is simply reporting the MIPS eligible clinician's or group's attestation on behalf of the clinician or group that the improvement activities were performed. The vendor is not attesting on its own behalf that the improvement activities were performed.

(a) Weighted Scoring

CMS finalizes its proposal for a weighted model for the improvement activities performance category with two categories: medium and high.

(b) Submission Criteria

CMS finalizes to achieve the highest potential score requires two high-weighted improvement activities (20 points each) or 4 medium-weighted activities (10 points each), or some combination of high- and medium-weighted activities for a total of 40 points.

CMS finalizes 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 finalizes for MIPS eligible clinicians and groups that are small practices, or practices located in rural areas or geographic HPSAs, 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 finalizes with a modification its proposed definition of rural area. CMS finalizes that a rural area means clinicians in zip codes designated as rural, using the most recent HRSA Area Health Resource File data set available.
- CMS finalizes a small practice means practices consisting of 15 or fewer clinicians and solo practitioners.
- CMS finalizes a Health Professional Shortage Area (HPSA) means an area as designated under section 332(a)(1)(A) of the Public Health Service Act.

CMS intends to provide targeted, practical technical assistance to solo and small practices.

CMS finalizes all clinicians identified on the Participation List of an APM will receive at least one-half of the highest score. CMS states that to develop the improvement additional score assigned to all MIPS APMs, CMS will compare the requirements of the specific APM with the list of activities in the improvement activities inventory and score those activities in the same manner that they are otherwise scored for MIPS eligible clinicians. If the MIPS APM does not receive the maximum improvement activities performance category score, then the APM entity will be able to submit additional improvement activities. CMS notes that all other MIPS eligible clinicians or groups that it identifies as participating in APMs will need to select additional improvement activities to achieve the highest score for this performance category.

(c) Required Period of Time for Performing an Activity. CMS finalizes its proposal that MIPS eligible clinicians or groups must perform improvement activities for at least 90 consecutive days during the performance period for an improvement activity credit. CMS also finalizes its proposal that where applicable, an improvement activity may have begun prior to the performance period or be adopted in the performance period as long as an activity is being performed for at least 90 days during the performance period.

(3) Improvement Activities Subcategories

MACRA requires that the improvement activities performance category must include at least the following subcategories: Expanded practice access; Population management; Care coordination; Beneficiary engagement; Patient safety and practice assessment; and Participation in an APM.

CMS is adding three additional subcategories to the improvement activities subcategories required in the statute. The finalized additional subcategories are: Achieving Health Equity; Integrated Behavioral and Mental Health; and Emergency Preparedness and Response.

Required Documentation

CMS states that MIPS eligible clinicians may retain any documentation that is consistent with they did when they performed each activity. CMS intends to provide more information about documentation for the 2017 performance year in subregulatory guidance.

CMS Study on Improvement Activities and Measurement. CMS finalizes its proposal to conduct a study on practice improvement and measurement to examine clinical quality workflows and data capture using a simpler approach to quality measures. Participants will receive a full credit (40 points) for the improvement activities performance category.

f. Advancing Care Information Performance Category

CMS intends to move MIPS beyond the measurement of EHR adoption and process measures and into a more patient-focused health IT program. The first step toward a more holistic approach to EHR measurement is to award a bonus score in the ACI category if a MIPS eligible clinician attests to completing certain improvement activities using CEHRT functionality. Table 8 in the final rule identifies eighteen improvement activities from the improvement activities inventory that are eligible for a bonus score in the ACI category. CMS finalizes a 10 percent bonus in the ACI category if a MIPS eligible clinician attests to completing at least one of the activities in Table 8 using CEHRT.

(1) Clinical Quality Measurements (CQMs)

CMS does not make any separate requirements for clinical quality measure (CQM) reporting within the ACI category. For the quality performance category, CMS finalizes requirements for the submission of quality data for specified measures and encourages reporting of CQMs with data captured in CEHRT.

(2) Performance Period Definition

CMS finalizes its proposal to align the performance period for the ACI performance category to the finalized MIP performance period of one full year. After consideration of comments received, CMS finalizes the following:

- For the 2017 performance period, CMS will accept a minimum of 90 consecutive days of data. CMS encourages MIPS eligible clinicians to report data for the full performance year.

- For the 2018 performance period, CMS will accept a minimum of 90 consecutive days of data reported. CMS encourages MIPS eligible clinicians to report data for the entire 2018 performance year.

(3) Advancing Care Information Performance Category Data Submission and Collection

(a) Definition of Meaningful EHR User and Certification Requirements.

CMS finalizes its proposal to define a meaningful EHR user for MIPS as a MIPS eligible clinician who possesses CEHRT, uses the functionality of CEHRT, and reports on applicable objectives and measures specified for the ACI performance category for a performance period as specified by CMS. CMS notes its definition of CEHRT for MIPS eligible clinicians is based on the definition that applies in the EHR Incentive Programs under §495.4.

In the 2015 EHR Incentive Programs final rule (80 FR 62873), CMS outlined the requirements for EPs using CEHRT in 2017 as it relates to the objectives and measures they select to report. CMS finalizes its proposal to have similar requirements under the MIPS ACI category.

For 2017, MIPS eligible clinicians will be able to use EHR technology certified to either the 2014 or 2015 Edition certification criteria as follows:

- A MIPS eligible clinician who only has technology certified to the 2015 Edition may choose to report:
 1. On the objectives and measures specified for the ACI category, which correlate to Stage 3 requirements; or
 2. On the alternative objectives and measures specified for this performance category, which correlate to modified Stage 2 requirements.
- A MIPS eligible clinician who has technology certified to a combination of 2015 and 2014 Edition may choose to report:
 1. On the objectives and measures specified for the ACI performance category, which correlate to Stage 3 requirements; or
 2. On the alternative objectives and measures specified for this performance category, which correlate to modified Stage 2 requirements, if they have the appropriate mix of technologies to support each measure selected.
- A MIPS eligible clinician who only has technology certified to the 2014 Edition will not be able to report on any of the measures specified for this performance category that correlate to Stage 3 requirements. These eligible clinicians will be required to report on the alternative objective and measures, which correlate to modified Stage 2 requirements.

Beginning with the 2018 performance period, MIPS eligible clinicians must only use technology certified to the 2015 Edition to meet the objectives and measures for this performance category, which correlate to Stage 3.

(b) Method of Data Submission.

CMS finalizes its proposal to allow the submission of ACI performance category data through qualified registry, EHR, QCDR, attestation, and CMS Web Interface submission methods. Regardless of data submission method, all MIPS eligible clinicians must follow the reporting

requirements for the objectives and measures to meet the requirements of the ACI performance category.

CMS notes that because of development efforts associated with this data submission capability, some Health IT vendors, QCDRs and qualified registries may not be able to submit this type of data submission for the 2017 performance period. Therefore it is offering the option of attestation.

(c) Group Reporting.

CMS is finalizing its proposal that individual MIPS eligible clinicians deciding to report as a group will have their performance assessed as a group for all performance categories. Therefore, the data submission criteria for the ACI performance category would be the same when submitted at the individual and group level, but the data submitted would be aggregated for all MIPS eligible clinicians within the group practice.

In response to commenters' concerns that group reporting for ACI in 2017 does not provide sufficient time to implement group reporting capabilities in CEHRT, CMS notes that group reporting provides a significant reduction in reporting burden for many group practices with a large number of MIPS eligible clinicians and that groups have the ability to report through multiple reporting mechanisms if their CEHRT cannot support group reporting in 2017.

The group will need to aggregate data for all the MIPS eligible clinicians within the group for whom they have data in CEHRT. Performance on the ACI performance category objectives and measures will be reported and evaluated at the group level, as opposed to the individual MIPS eligible clinician level. For example, the group calculation of the numerators and denominators for each measure must reflect all of the data from all individual MIPS eligible clinicians that have been captured in CEHRT for the ACI measure. If the group practice has CEHRT that is capable of supporting group reporting, the group will submit the aggregated data produced by the CEHRT. Otherwise, the group will need to aggregate the data by adding together the numerators and denominators for each MIPS eligible clinician within the group for whom the group has data captured in the CEHRT. If an individual MIPS eligible clinician meets the criteria to exclude a measure, their data can be excluded from the calculation of that particular measure only.

CMS acknowledges it can be difficult to identify unique patients across a group for the purpose of aggregating performance on the ACI measures. CMS stated that it considers "unique patients" to be individual patients treated by the group who would be typically counted as one patient in the denominator of an ACI measure. CMS notes that a unique patient may see multiple MIPS eligible clinicians within the group, or may see MIPS eligible clinicians at multiple group locations. When aggregating performance on ACI measures for group reporting, CMS is not requiring that the group determine that a patient seen by one MIPS eligible clinician is not seen by another MIPS eligible clinician in the group or captured in a different CEHRT system. CMS states that it believes the burden to the group of identifying these patients is greater than any gain in measurement activity.

(4) Reporting Requirements and Scoring Methodology

CMS finalizes its proposal 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 is finalizing its proposal that the score would be comprised of a score for participation and reporting, referred to as the "base score", and a score for performance at varying levels above the base score requirements, referred to as the "performance score".

The finalized ACI reporting requirements and scoring methodology are summarized in Table 9 and Table 10 in the final rule and reproduced below at the end of this section.

(a) Base Score

CMS finalizes with modifications the primary proposal for the scoring methodology for the base score. CMS reduces the number of required measures from eleven in the proposed base score to five required measures in the finalized base score. CMS finalizes a MIPS eligible clinician must report all required measures in the base score ("all-or-none") to earn a score in the ACI performance category.

(i) Privacy and Security; Protect Patient Health Information. In the 2015 EHR Incentive Program Final Rule (80 FR 62832), CMS finalized the Protect Patient Health Information objective and its associated measure for Stage 3, which requires EPs to protect electronic protected health information (ePHI) created or maintained by CEHRT through the implementation of appropriate technical, administrative, and physical safeguards. CMS finalizes its proposal that a MIPS eligible clinician must meet this objective and measure in order to earn any score within the ACI performance category. Failure to do so would result in a base score of zero, a performance score of zero, and an advancing care information performance category score of zero.

(ii) ACI Performance Category Base Score

CMS finalizes its primary proposal that MIPS eligible clinicians must report either a one in the numerator for numerator/denominator measures, or a "yes" response for yes/no measures for each measure within a subset of objectives adopted in the 2015 EHR Incentive Programs, in order to earn points in the base score. CMS finalizes for the base score five measures that are required to be reported: Security Risk Analysis, e-Prescribing, Provide Patient Access, Send a Summary of Care, and Request/Accept Summary of Care.

Computerized physician order entry (CPOE) and clinical decision support (CDS) objectives are not required objectives and measures for reporting. Further, an eligible clinician does not need to complete submission on the Immunization Registry Reporting measure for the base score. Failure to meet the submission criteria (numerator/denominator or yes/no statement as applicable) for any measure in any of the objectives would result in a score of zero for the category.

For the Public Health and Clinical Data Registry Reporting objective, CMS does not finalize its proposal that as part of the base score an eligible clinician would need to complete submission on the Immunization Registry Reporting measure. Instead, CMS finalizes MIPS eligible clinicians

can earn 10 percent in the performance score for reporting this measure. CMS finalizes completing any additional public health or clinical data registries under this objective would earn five, instead of the proposed one, additional bonus percentage points in the performance category score. This 5 percent bonus score is only available to MIPS eligible clinicians who earn a base score.

(iii) 2017 ACI Transition Objectives and Measures (Referred to in the proposed rule as Modified Stage 2 in 2017). CMS finalizes its proposal for reporting on the Modified Stage 2 objectives and measures for the ACI performance category in 2017 for these MIPS eligible clinicians. CMS will use the same scoring and data submission requirements as the finalized base requirements. The finalized ACI reporting requirements and scoring methodology are summarized in Table 10 in the final rule and reproduced below at the end of this section.

(b) Performance Score. CMS finalizes with a modification its proposal that a MIPS eligible clinician would earn additional points above the base score for performance on nine (instead of the proposed eight) measures under the Patient Electronic Access, Coordination of Care through Patient Engagement, Health Information Exchange, and Public Health and Clinical Data Registry Reporting objectives. CMS finalizes the Immunization Registry Reporting measure as a performance measure.

CMS finalizes that the nine associated measures would each be assigned a total of 10 possible percentage points. An eligible clinician has the potential to earn a performance score of up to 90 percentage points. The combination of the performance score with the base score would provide a total score that is more than the total possible 100 percent for the advancing care information performance category. This allows flexibility for eligible clinicians to focus on measures that are most relevant to their practice to achieve the maximum performance score.

The performance score is based on a MIPS eligible clinician's performance rate for each measure reported for the performance score (calculated using the numerator/denominator). A performance rate of 1-10 percent will earn a 1 percentage point, a performance rate of 11-20 percent will earn 2 percentage points and so on. As illustrated in a CMS example, if a clinician reports a numerator/denominator of 85/100 for the Patient-Specific Education measure, the performance rate will be 85 percent and he or she will earn 9 percentage points towards the performance score.

(c) Overall Advancing Care Information Performance Category Score (Table 9). CMS finalizes to sum the base score, performance score and any additional bonus score, if applicable to obtain the overall score for this performance category. CMS finalizes:

- A MIPS eligible clinician must report all required measures of the base score to earn any base score, and thus earn any score in the ACI performance category (“all-or-none”). The base score is 50 percent of the ACI performance category score. CMS finalizes five required measures, instead of the proposed eleven measures.
- A MIPS eligible clinician has the ability to earn up to 90 percentage points if he or she reports all the measures in the performance score. CMS finalized nine measures instead of the proposed eight measures.

- A MIPS eligible clinician has the ability to earn bonus points if he or she reports Public Health and Clinical Data Registry Objectives. MIPS eligible clinicians are not required to report the Immunization Registry Reporting measure in order to earn the bonus 5 percent for reporting to one or more additional registries.

CMS explains that MIPS eligible clinicians have the ability to earn an overall score for the ACI category of up to 155 percentage points, which will be capped at 100 percent when the base score, performance score, and bonus score are added together.

CMS also finalizes its final scoring methodology for the 2017 ACI Transition objectives and measures (referred to in the proposed rule as the Modified Stage 2 Objectives and Measures (Table 10). CMS finalizes MIPS eligible clinicians reporting the 2017 ACI Transition objectives and measures will have the ability to also earn an overall score of up to 155 percentage points, which will be capped at 100 percent when the base score, performance score, and bonus score are added together. CMS notes that in order to make up the differences in the number of measures included in the performance score for the two measure sets, it increased the number of percentage points available for the performance weight of the Provide Patient Access and Health Information Exchange measure (up to 20 percent for each measure).

Table 9: Advancing Care Information Performance Category Scoring Methodology
Advancing Care Information Objectives and Measures

ACI Objective	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
	Immunization Registry Reporting	Not Required	0 or 10%	Yes/No Statement

Public Health and Clinical Data Registry Reporting	Syndromic Surveillance Reporting	Not Required	Bonus	Yes/No Statement
	Electronic Case Reporting	Not Required	Bonus	Yes/No Statement
	Public Health Registry Reporting	Not Required	Bonus	Yes/No Statement
	Clinical Data Registry Reporting	Not Required	Bonus	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

Table 10: Advancing Care Information Performance Category Scoring Methodology for 2017 Advancing Care Information Transition - Objectives and Measures

ACI Transition Objective (2017 only)	ACI Transition Measure (2017 only)	Required/Not Required for Base Score (50%)	Performance Scoring (up to 90%)	Reporting Requirement
Protect Patient Health Information	Security Risk Analysis	Required	0	Yes/No Statement
Electronic Prescribing	e-Prescribing	Required	0	Numerator/Denominator
Patient Electronic Access	Provide Patient Access	Required	Up to 20%	Numerator/Denominator
	View, Download, or Transmit (VDT)	Not Required	Up to 10%	Numerator/Denominator
Patient-Specific Education	Patient-Specific Education	Not Required	Up to 10%	Numerator/Denominator
Secure Messaging	Secure Messaging	Not Required	Up to 10%	Numerator/Denominator
Health Information Exchange	Health Information Exchange	Required	Up to 20%	Numerator/Denominator
Medication Reconciliation	Medication Reconciliation	Not Required	Up to 10%	Numerator/Denominator
Public Health Reporting	Immunization Registry Reporting	Not Required	0 or 10%	Yes/No Statement
	Syndromic Surveillance Reporting	Not Required	Bonus	Yes/No Statement
	Specialized Registry Reporting	Not Required	Bonus	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

(5) Advancing Care Information Performance Category Objectives and Measures Specifications

CMS finalizes its proposal to use objectives and measures that have been adapted from the Stage 3 objectives and measures finalized in the 2015 EHR Incentive Programs Final Rule (80 *FR* 62829 – 62871); CMS does not maintain the previously established threshold for MIPS. CMS also finalizes its proposal to use Modified Stage 2 objectives and measures that have been adapted from the Stage 3 objectives and measures finalized in the 2015 EHR Incentive Programs Final Rule (80 *FR* 62793 – 62825); CMS also does not maintain the previously established threshold for MIPS. The reader is referred to the final rule for a detailed discussion of the comments CMS received and the final specifications for the ACI performance category objectives and measures.

(6) Reweighting of the Advancing Care Information Performance Category for MIPS Eligible Clinicians without Sufficient Measures Applicable and Available

(a) Physician MIPS Eligible Clinicians. Section 1848(q)(5)(F) of the Act provides that if there are not sufficient measures and activities applicable to each type of MIPS eligible clinician, the Secretary shall assign different scoring weights (including a weight of zero) for each performance category based on the extent to which the category is applicable to each type of MIPS eligible clinician. CMS states that under the finalized ACI performance category, there may not be sufficient measures that are applicable and available to certain types of MIPS eligible clinicians, and CMS will assign a weight of zero to the ACI performance category for purposes of calculating a final score for the following MIPS eligible clinicians:

- Hospital-based eligible clinicians,
- MIPS eligible clinicians facing a significant hardship, and
- Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists.

Hospital-Based MIPS Eligible Clinicians. The finalized definition of hospital-based MIPS eligible clinician is 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.

If a MIPS eligible clinician believes there are sufficient ACI measures applicable to them, he or she has the option to report the ACI measures for the performance period for which they are determined hospital-based. If an exempted hospital-based clinician reports on the ACI measures,

he or she will be scored and the category will be weighted in the same manner for as all other MIPS eligible clinicians.

MIPS Eligible Clinicians Facing a Significant Hardship. CMS finalizes its proposal to use the significant hardship categories it defined in the Stage 2 Final Rule (77 FR 54097 -54100):

- Insufficient internet connectivity,
- Extreme and uncontrollable circumstances,
- Lack of control over the availability of CEHRT, and
- Lack of face-to-face patient interaction.

To demonstrate insufficient internet connectivity and be considered for a reweighting of this performance category, CMS requires MIPS eligible clinicians to demonstrate insufficient internet access through an application process. Eligible clinicians will have to demonstrate they lacked sufficient internet access during the performance period, and that there were insurmountable barriers to obtaining a necessary infrastructure, such as a high cost of extending the internet infrastructure to their facility.

Extreme and uncontrollable circumstances, such as natural disasters in which an EHR or practice buildings are destroyed, can prevent a MIPS eligible clinician from being able to access CEHRT.

To demonstrate lack of control over the availability of CEHRT and be considered for a reweighting of this performance category, a MIPS eligible clinicians will need to submit an application demonstrating that a majority (50 percent or more) of their outpatient encounters occur in locations where they have no control over the health IT decisions of the facility. Control does not imply final decision-making authority; CMS will generally view eligible clinicians practicing in a large group as having control over the availability of CEHRT. In contrast, a surgeon using an ambulatory surgery center and a physician treating patients in a nursing home (if these clinicians do not have any other vested interest in the facilities) may not have influence or control over the health IT decisions at the facilities.

MIPS eligible clinicians will have to annually submit an application that included information about why the EHR technology is not available and the related duration the technology will be unavailable as a result of a lack of internet, uncontrollable circumstances, or lack of control over certified technology. CMS states that additional information on the submission process will be made available later this year.

Many of the measures under the advancing care information performance category require face-to-face interaction with patients. Therefore CMS will automatically reweight this performance category 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) without requiring an application to be submitted by the eligible clinician.

If a MIPS eligible clinician with a significant hardship exception believes there are sufficient ACI measures applicable to them, they have the option to report the ACI measures for the performance period for which they have an exception. If an exempted clinician reports on the

ACI measures, they will be scored and the category will be weighted in the same manner as for all other MIPS eligible clinicians.

Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists. CMS will assign a weight of zero to this performance category if there are 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.

Medicaid. CMS does not make any changes to the objectives and measures previously established for the Medicaid EHR Incentive Program. Reporting on the measures specified for the ACI performance category under MIPS cannot be used as a demonstration of meaningful use for the Medicaid EHR Incentive Program. Similarly, demonstrating meaningful use in the Medicaid EHR Incentive Program cannot be used for purposes of reporting under MIPS. MIPS eligible clinicians must report their data for the ACI performance category through the submission methods established for MIPS. These eligible clinicians must separately demonstrate meaningful use in their state's Medicaid EHR Incentive Program in order to earn a Medicaid incentive payment.

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

CMS finalizes a scoring standard for MIPS eligible clinicians participating in certain types of APMs. This will reduce participant reporting burden by eliminating the need for APM eligible clinicians to submit data for both MIPS and their respective APMs. CMS finalizes it will use the APM scoring standard for MIPS eligible clinicians in APM Entity groups participating in certain APMs that meet the criteria discussed below and are identified as "MIPS APM" on the CMS website.

(1) Criteria for MIPS APM

CMS finalizes MIPS APMs are APMs that meet the following criteria:

1. APM Entities participate in the APM under an agreement with CMS or by law or regulation;
2. The APM requires that APM Entities include one or more MIPS eligible clinicians on a Participation List; and
3. The APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on cost/utilization and quality measures.

The APM scoring standard will not apply to MIPS eligible clinicians participating in APMs that are not MIPS APMs. The criteria for the identification of MIPS APMs are independent of the criteria for Advanced APM determinations, therefore a MIPS APM may or may not also be an Advanced APM.

CMS will not allow the APM scoring standards to apply to providers that are not identified as actual participants in MIPS APMs.

The finalized QP Performance Period modifies the proposed QP determination timeframe so that eligible clinicians who are QPs for a year will know in advance of the performance year and not need to report MIPS data. An eligible clinician that is in an Advanced APM but does not meet the QP threshold will still be subject to MIPS.

(2) APM Scoring Standard Performance Period

The performance period for MIPS eligible clinicians participating in MIPS APMs would generally match the applicable calendar year performance period proposed for MIPS.

- For a new MIPS APM for which the first APM performance period begins after the start of the corresponding MIPS performance period, the participating MIPS eligible clinicians will submit data to the MIPS in the first MIPS performance period for the APM either as individual MIPS eligible clinicians or as a group, and report to CMS using the APM scoring standard for subsequent MIPS performance periods.
- CMS anticipates that there might be MIPS APMs that are in their last year of operation that might not be able to use the APM scoring system, even though they met the criteria for the APM scoring standard and the eligible clinicians were considered as a MIPS APM in the prior performance period. If CMS determines it is not feasible for the MIPS eligible clinicians participating in the APM Entity to report to MIPS using the APM scoring standard in an APM's last year of operation, the eligible clinicians will need to submit data to MIPS either as individual eligible clinicians or as a group. CMS will notify eligible clinicians in the MIPS APM in advance of the relevant MIPS performance period.

CMS will maintain the 12-month performance period for the APM scoring standard, but data submitted for the ACI and, if necessary, improvement activities performance categories will follow the generally applicable MIPS data submission requirements. The quality performance data for MIPS APM will be submitted in accordance with the specific reporting requirements of the APM.

CMS will post the list of MIPS APMs prior to the first day of the MIPS performance period for each year. If the APM would have qualified as a MIPS APM but the APM is ending before the end of the performance period, the APM will not appear on this list and CMS will notify participants in these APMs in advance of the start of the performance period.

(3) How the APM Scoring Standard Differs from the Assessment of Groups and Individual MIPS Eligible Clinicians Under MIPS

CMS finalizes its proposed APM scoring standard that it considers similar to the finalized group assessment under MIPS except for the following:

- Depending on the terms and conditions of the MIPS APM, an APM Entity could be comprised of a sole MIPS eligible clinician (for example, a physician practice with only one eligible clinician could be considered an APM Entity);

- The APM Entity could include more than one unique TIN, as long as the MIPS eligible clinicians are identified as participants in the APM by their unique APM participant identifiers; and
- The composition of the APM Entity group could include APM participant identifiers with TIN/NPI combinations such that some MIPS eligible clinicians in a TIN are APM participants and other MIPS eligible clinicians in the same TIN are not APM participants.

In contrast, assessment as a group under MIPS requires a group to be comprised of at least two MIPS eligible clinicians who have assigned their billing rights to a TIN. In addition all MIPS eligible clinicians in the group use the same TIN.

For the APM scoring standard, CMS will generate a MIPS final score by aggregating all scores for eligible clinicians in the APM Entity that are participating in the MIPS APM to the level of the APM Entity.

In response to a comment, CMS clarifies how reporting will be accomplished in groups where MIPS eligible clinicians participate in multiple APMs. If a single TIN/NPI combination for a MIPS eligible clinician is in two or more MIPS APMs, it will use the highest final score to determine the MIPS payment adjustment for that MIPS eligible clinician. MIPS adjustments apply to the TIN/NPI combination, so if a MIPS eligible clinician participates in multiple MIPS APMs with different TINs, each of the TIN/NPI combinations would be assessed separately under each respective APM Entity.

Depending on the type of MIPS APM, the weights associated with performance categories may be different than the generally applicable weights for MIPS eligible clinicians. As discussed below:

- Under the APM scoring standard, the weight for the cost performance category will be zero.
- For certain APMs, the weight for the quality performance category will be zero for the 2019 payment year. Neither the APM Entity nor the eligible clinicians would need to report quality performance data.

CMS will redistribute the weights for the quality and cost performance categories to the improvement activities and ACI performance categories to maintain a final score of 100 percent.

(4) APM Participant Identifier and Participant Database

Each APM Entity will be identified in the MIPS program by a unique APM Entity identifier, and that the unique APM participant identifier for a MIPS eligible clinician will be a combination of four identifiers, including (1) APM identifier (established by CMS); (2) APM Entity identifier (established by CMS); (3) the eligible clinician's billing TIN; and (4) NPI (discussed in section II.B.2). For purposes of the APM scoring, the ACO would be the APM entity. CMS will use the established criteria for determining the list of eligible clinicians participating under an ACO to determine the list of MIPS eligible clinicians included in an APM Entity group for determining the APM scoring standard. CMS will do this annually.

CMS will establish and maintain an APM participant database based on the APM Participation List that will include all of the MIPS eligible clinicians who are part of the APM Entity. CMS finalizes will review the MIPS APM Participation Lists on March 31, June 30 and August 31. All eligible clinicians who appear on an APM Entity's list for a MIPS APM on at least one of those three dates will be included in the APM Entity group for purposes of the APM scoring standard for the year.

If a MIPS eligible clinician is not on the APM's Participation List on at least one of the finalized dates, then the MIPS eligible clinician will need to submit data to MIPS using the MIPS individual or group reporting options. If the applicable data submission requirements include full year reporting, the MIPS individual or group would need to report for the full year.

(5) APM Entity Group Scoring for the MIPS Performance Categories

CMS will calculate one final score at the APM Entity group level that will be applied to the billing TIN/NPI combination of each MIPS eligible clinician in the APM Entity group. CMS will also give one-half of the maximum improvement activities score to eligible clinicians who are APM participants. Improvement activities scoring credit extends to any MIPS eligible clinician who is identified by an APM participant identifier on a Participation List, an Affiliated Practitioner List, or other CMS-maintained list of participants at any time during the MIPS performance period.

If a Shared Savings Program ACO does not report quality data as required under the Shared Savings Program regulations, then scoring on all MIPS performance categories will be at the ACO participant TIN level, and the resulting TIN-level final score will be applied to each of its TIN/NPI combinations. For purposes of both the Shared Savings Program quality performance requirement and the APM scoring standard, any "partial" reporting of quality measures through the CMS Web Interface that does not satisfy the quality reporting requirements under the Shared Savings Program will be considered a failure to report. In this scenario, each ACO participant TIN would need to report quality data to MIPS according to MIPS group reporting requirements in order to avoid a zero for the quality performance category.

There may be instances when an APM Entity's participation in the APM is terminated during the MIPS performance period. CMS will make the first assessment to determine whether a MIPS eligible clinician is on the APM Entity's Participation List on March 31 of the performance period. If the APM Entity terminates its participation in the APM prior to March 31, the MIPS eligible clinician will not be considered part of the APM Entity group for the APM scoring standard; if an APM Entity terminates its participation in the APM on or after March 31 of a performance period the MIPS eligible clinician will still be considered part of the APM Entity group in a MIPS APM for the year and will report and be scored under the APM scoring system.

(6) Shared Savings Program

Table 11 in the final rule (copied at the end of this section) summarizes CMS' finalized APM standard scoring for MIPS eligible clinicians participating in a Shared Savings Program ACO.

Quality Performance Category Scoring. A Shared Savings Program ACO's quality data reported to the CMS Web Interface as required by the Shared Savings Program rules will also be used for purposes of scoring the MIPS quality performance category using MIPS performance benchmarks.

Practices may participate in both a Comprehensive Primary Care Plus (CPC+) model and in a Shared Savings Program ACO. For purposes of the APM scoring standard, MIPS eligible clinicians with dual participation will be considered part of the Shared Savings Program ACO. CPC+ practices that are part of a Shared Savings Program ACO will report quality to CPC+ as required by the CPC+ model but will not receive the CPC+ performance-based incentive payment.

Cost Performance Category Scoring. CMS will reduce the cost performance weight to zero percent and to evenly redistribute the 10 percent cost performance category weight to the improvement activities and ACI performance categories. The zero weight for the cost performance for APM Entity groups in the Shared Savings Program will remain until it is modified through future rulemaking.

Improvement Activities and the Advancing Care Information Performance Category Scoring. An APM Entity group in the Shared Savings Program, Next Generation ACO Model and other MIPS APMs, will receive a baseline score based on the improvement activity requirements under the terms of the particular MIPS APM. CMS will review the MIPS APM requirements and assign an improvement activities score for each MIPS APM that is applicable to all APM Entity groups participating in the MIPS APM⁶. To develop the improvement activities score, CMS will compare the requirements of the MIPS APM with the MIPS improvement activities measures and score the measures in the same manner that they would otherwise be scored for MIPS eligible clinicians. In the event that a MIPS APM does not incorporate sufficient improvement activities to receive the maximum improvement activities score, APM Entities will have the opportunity to report and add points to the baseline MIPS APM-level score on behalf of all MIPS eligible clinicians in the APM Entity group.

For the ACI performance category all eligible clinicians will submit data through their respective ACO participant TINs and the TIN scores would be aggregated as a weighted average based on the number of MIPS eligible clinicians in each TIN to yield one APM Entity group score. In the event a Shared Savings Program ACO fails to satisfy quality reporting requirements for measures reported through the CMS Web Interface, ACI group TIN scores will not be aggregated to the APM Entity level. Instead each ACO participant TIN will be scored separately based on its TIN-level group reporting for the ACI performance category.

⁶ The CMS document, Scores for Improvement Activities in MIPS APMs in the 2017 Performance Period, summarized the improvement activities category score CMS will assign to MIPS APMs. The document, dated October 14, 2016, is accessed at <https://qpp.cms.gov/education>.

Table 11: APM Scoring Standard for the Shared Savings Program – 2017 Performance Period for the 2019 Payment Adjustment

MIPS Performance Category	APM Entity Submission Requirement	Performance Score	Performance Category Weight
Quality	Shared Savings Program ACOs submit quality measures to the CMS Web Interface on behalf of their participating MIPS eligible clinicians.	The MIPS quality performance category requirements and benchmarks will be used to determine the MIPS quality performance category score at the ACO level.	50%
Cost	MIPS eligible clinicians will not be assessed on cost.	Not applicable	0%
Improvement Activities	ACOs only need to report if the CMS-assigned improvement activities score is below the maximum improvement activities score.	CMS will assign the same improvement activities score to each APM Entity group based on the activities required of participants in the Shared Savings Program. The minimum score is one half of the total possible scores. If the assigned score does not represent the maximum improvement activities score, ACOs will have the opportunity to report additional improvement activities to add points to the APM Entity group score.	20%
Advancing Care Information (ACI)	All ACO participant TINs in the ACO submit under this category according to the MIPS group reporting requirements.	All of the ACO participant TIN scores will be aggregated as a weighted average based on the number of MIPS eligible clinicians in each TIN to yield one APM Entity group score.	30%

(7) Next Generation ACO Model

Table 12 in the final rule (copied at the end of this section) summarizes CMS' finalized APM scoring standard for MIPS eligible clinicians participating in a Next Generation ACO Model. Except as noted below, the APM scoring standard for MIPS eligible clinicians are similar for both the MSSP ACOs and the Next Generation ACO Model.

Advancing Care Information Performance Category. CMS will attribute one ACI score to each MIPS eligible clinician in an APM Entity by looking at both individual and group data submitted for a MIPS eligible clinician and use the highest reported score. Each MIPS eligible clinician in the APM Entity will receive one score, weighted equally with that of the other clinicians in the group, and CMS will calculate a single APM Entity-like ACI performance category score. If there is no group or individual score, CMS will attribute a zero to the MIPS eligible clinician, which will be included in the aggregate APM Entity score.

**Table 12: APM Scoring Standard for the Next Generation ACO Model – 2017
Performance Period for the 2019 Payment Adjustment**

MIPS Performance Category	APM Entity Submission Requirement	Performance Score	Performance Category Weight
Quality	ACOs submit quality measures to the CMS Web Interface on behalf of their participating MIPS eligible clinicians.	The MIPS quality performance category requirements and benchmarks will be used to develop the MIPS quality score performance score at the ACO level.	50%
Cost	MIPS eligible clinicians will not be assessed on cost.	Not applicable	0%
Improvement Activities	ACOs only need to report if the CMS-assigned improvement activities score is below the maximum improvement activities score.	CMS will assign the same improvement activities score to each APM Entity group based on the activities required of participants in the Next Generation ACO Model. The minimum score is one half of the total possible scores. If the assigned score does not represent the maximum improvement activities score, ACOs will have the opportunity to report additional improvement activities to add points to the APM Entity group score.	20%
Advancing Care Information (ACI)	Each MIPS eligible clinicians in the APM Entity group reports ACI to MIPS through either group reporting at the TIN level or individual reporting.	CMS will attribute one score to each MIPS eligible clinician in the APM Entity group. This score will be the highest score attributable to the TIN/NPI combination of each MIPS eligible clinician, which may be derived from either group or individual reporting. The scores attributed to each MIPS eligible clinician will be averaged to yield a single APM Entity group score.	30%

(8) Other MIPS APMs

Table 13 in the final rule (copied at the end of this section) summarizes CMS' finalized APM scoring standard for MIPS eligible clinicians participating in other MIPS APMs. Except as noted below, the APM scoring standard for MIPS eligible clinicians are similar for both the MSSP ACOs and the Next Generation ACO Model.

Quality Performance Category. For the first MIPS performance period only, for MIPS eligible clinicians participating in APM Entity groups in MIPS APMs (other than the Shared Savings or Next Generation), it will reduce the weight of the quality performance category to zero. APM Entities in MIPS APMs are, under the policies adopted in the final rule, required to base payment incentives on cost/utilization and quality measure performance. Thus, APMs will continue to report quality as required under the APM requirements and are not truly exempt from quality assessment for the year.

CMS also finalizes the inclusion of a MIPS quality performance category score under the APM scoring standard for the 2018 performance year and will develop additional scoring policies for 2018 through future rulemaking.

Cost Performance Category. For the first MIPS performance period only, for MIPS eligible clinicians participating in AMP Entity groups in MIPS APMs (other than the Shared Savings or Next Generation), CMS will reduce the weight of the resource use performance category to zero.

Non-APM participants in a clinical practice will report to MIPS under the generally applicable MIPS requirements for reporting as an individual or a group. If the clinical practice decides to report to MIPS as a group under its TIN, then its reporting may include some data from the MIPS APM participants.

Table 13: APMs Scoring Standard for MIPS APMs Other Than the Shared Savings Program and Next Generation ACO Model – 2017 Performance Period for the 2019 Payment Adjustment

MIPS Performance Category	Alternative Payment Entity Data Submission Requirement	Performance Score	Performance Category Weight
Quality	The APM Entity group will not be assessed on quality under MIPS in the first performance period. The APM Entity group will submit quality measures to CMS required by the APM.	Not applicable	0%
Cost	MIPS eligible clinicians will not be assessed on cost.	Not applicable	0%
Improvement Activities	APM Entities only need to report if the CMS-assigned improvement activities score is below the maximum improvement activities score	CMS will assign the same improvement activities score to each APM Entity group based on the activities required of participants in the MIPS APM. The minimum score is one half of the total possible scores. If the assigned score does not represent the maximum improvement activities score, APM Entities will have the opportunity to report additional improvement activities to add points to the APM Entity group score.	25%
Advancing Care Information (ACI)	Each MIPS eligible clinicians in the APM Entity group reports ACI to MIPS through either group reporting at the TIN level or individual reporting.	CMS will attribute one score to each MIPS eligible clinician in the APM Entity group. This score will be the highest score attributable to the TIN/NPI combination of each MIPS eligible clinician, which may be derived from either group or individual reporting. The scores attributed to each MIPS eligible clinician will be averaged to yield a single APM Entity group score.	75%

(9) APM Entity Data Submission Performance

Table 14 in the final rule (copied below) summarizes the APM Entity data submission mechanisms for reporting data for each MIPS performance category.

Table 14: APM Entity Submission Method for Each MIPS Performance Category

MIPS Performance Category	APM Entity Eligible Clinician Submission Method
Quality	The APM Entity group submits quality measure data to CMS as required under the APM.
Cost	No data submitted by APM Entity group to MIPS.
Improvement Activities	No data submitted by APM Entity group to MIPS unless the assigned score at the MIPS APM level does not represent the maximum improvement activities score, in which case the APM Entity may report additional improvement activities using a MIPS data submission mechanism.
Advancing Care Information (ACI)	Shared Savings Program ACO participant TINs submit data using a MIPS data submission mechanism. Next Generation ACO Model and other MIPS eligible clinicians submit data at either the individual level or at the TIN level using a MIPS data submission mechanism.

(10) MIPS APM Performance Feedback

The September 2016 QRUR will be used to satisfy the requirement to provide MIPS eligible clinicians performance feedback on the quality and cost performance categories. All MIPS eligible clinicians scored under the APM scoring standard will also receive this performance feedback to the extent applicable. MIPS eligible clinicians without data included in the September 2016 QRUR will not receive performance feedback until it is able to use data acquired through the QPP for performance feedback.

6. MIPS Final Score Methodology (§414.1380)

a. General approach

CMS establishes the initial MIPS payment year 2019 as a transition year. Under the transition year scoring:

- MIPS eligible clinicians who do not submit any data to MIPS during the performance period will receive a -4 percent payment adjustment in 2019.
- MIPS eligible clinicians who submit data and meet program requirements under any of the three active categories (quality, improvement activities, and advancing care information) and have low overall performance in those categories may receive a final score that provides them a neutral to small positive adjustment, and
- MIPS eligible clinicians who submit data and meet program requirements under each of the three active categories for at least a 90-day period and have average to high overall performance may/will receive a final score that gives them a higher positive adjustment, and if the score exceeds the performance threshold may receive an additional positive adjustment.

The definition of a MIPS payment year is a calendar year in which the MIPS payment adjustment factor (and if applicable, the additional MIPS adjustment factor) are applied to Medicare Part B payments.

The final rule provides that during the calendar year 2017 performance period for the MIPS 2019 payment adjustment, data must be provided for a continuous period of at least 90 days. There are “special” circumstances under which a MIPS eligible clinician may submit data for a period of less than 90 days and avoid a negative adjustment. For example, the data completeness criteria for some quality measures may be met in less than a 90-day period. Further, CMS will provide partial credit for data submission on quality measures when the data completeness criteria are not met.

CMS finalizes the term, performance standards, as the level of performance and methodology that the MIPS eligible clinician is assessed on for a MIPS performance period at the measures and activities level for all MIPS performance categories. The performance standard *methodology* will be known in advance, and that the performance standards themselves will be known in advance for the improvement activities and advancing care information categories.

For the quality category, benchmarks will be known prior to the performance period for those measures where the benchmark is established using a baseline period. For measures where no baseline data are available (e.g. cost category), the benchmarks will be based on the performance period and therefore will not be known in advance. CMS notes that for cost measures (not relevant in the 2017 transition year for the 2019 MIPS payment year) clinicians will not know the benchmarks in advance, but they will receive feedback on their past performance prior to the performance period which it says will help them improve their performance.

The scoring methodologies will be applied in the same manner for submissions by individuals, the proposed TIN/NPI, or group submissions using the TIN identifier. In this section of the final rule (and this summary) CMS references to “MIPS eligible clinician” refer to both individual and group reporting and scoring, but do not refer to an APM Entity group. The scoring standards would apply to MIPS eligible clinicians who participate in APMs that are not MIPS APMs and who therefore report to MIPS as an individual or a group.

CMS finalizes its general proposals regarding performance standards across the four categories.

- For the quality and cost performance categories, all measures would be converted to a 10-point scoring system, which permits comparison across different types of MIPS eligible clinicians.
- As noted above, performance standards would be published, where feasible, before the performance period begins.
- In accordance with MACRA, failure to report on a required measure or activity will result in zero points for that measure or activity.
- The scoring system will ensure sufficient reliability and validity, by only scoring the measures that meet certain standards (such as required case minimum).
- The scoring proposals provide incentives for MIPS eligible clinicians to invest and focus on certain measures and activities that meet high priority policy goals such as improving

beneficiary health, improving care coordination through health information exchange, or encouraging APM Entity participation.

- Performance at any level will receive points towards the performance category scores.

The change in the quality performance category is that for the 2019 MIPS payment year, a minimum 3-point floor applies for all submitted measures. This transition year floor will apply regardless of whether the measure lacks a benchmark or if the clinician does not meet the case minimum or data completion requirements for the measure.

A MIPS eligible clinician may elect to submit information via multiple mechanisms, but must use the same identifier for all performance categories and may only use one submission mechanism for each performance category. For example, an eligible clinician may use one mechanism for submitting quality measures and a different one for improvement activities data, but all quality measures must be submitted using the same mechanism. In rare cases where multiple submission mechanisms are used for a single category, CMS will score all the options and use the highest performance score for the category. It will not combine data from multiple submission mechanisms to calculate an aggregated performance score, with the exception of the CAHPS for MIPS, which must be submitted using a CMS-approved vendor, and can be scored in conjunction with other submission mechanisms.

The baseline period for quality measures (with the exception of new measures) will be the period that is two years prior to the performance period for a MIPS payment year. For the 2019 payment year, the baseline period is 2015, which is two years prior to the 2017 performance period. CMS says that this is the most recent data that can be used to develop benchmarks prior to the performance period.

Table 15, reproduced from the final rule, describes the performance standards finalized for the 2017 performance period for each of the four MIPS performance categories and compares them with the proposed rule. Details on the final standards are described in items b through e of this section of this summary.

TABLE 15: Performance Category Performance Standards for the 2017 Performance Period

Performance Category	Proposed Performance Standard	Final Performance Standard
Quality	Measure benchmarks to assign points, plus bonus points.	Measure benchmarks to assign points, plus bonus points with a minimum floor for all measures.
Cost	Measure benchmarks to assign points.	Measure benchmarks to assign points.
Improvement Activities	Based on participation in activities that align with the patient-centered medical home. Number of points from reported activities compared against a	Based on participation in activities listed in Table H of the Appendix to the final rule with comment period.

	highest potential score of 60 points.	Based on participation as a patient-centered medical home or comparable specialty practice. Based on participation as an APM. Based on participation in the CMS study on improvement activities and measurement. Number of points from reported activities or credit from participation in an APM compared against a highest potential score of 40 points.
Advancing Care Information	Based on participation (base score) and performance (performance score). Base score: Achieved by meeting the Protect Patient Health Information objective and reporting the numerator (of at least one) and denominator or yes/no statement as applicable (only a yes statement would qualify for credit under the base score) for each required measure. Performance score: decile scale for additional achievement on measures above the base score requirements, plus 1 bonus point.	Based on participation (base score) and performance (performance score). Base score: Achieved by meeting the Protect Patient Health Information objective and reporting the numerator (of at least one) and denominator or yes/no statement as applicable (only a yes statement would qualify for credit under the base score) for each required measure. Performance score: Between zero and 10 or 20 percent per measure (as designated by CMS) based upon measure reporting rate, plus up to 15 percent bonus score.

CMS discusses the requirements for scoring both achievement and improvement. Improvement will not be scored in the first year of MIPS implementation, and will begin in the second year if sufficient data were available. Additional discussion on this issue is provided below in the next section of this summary.

b. Scoring the Quality Performance Category

The same scoring methodology will be used regardless of how the data are submitted.

Overview

For the transition year, 3 to 10 points will be assigned to each measure, based on a clinician's performance compared to benchmarks. This reflects adoption of a global 3-point minimum score for quality measures during the transition year. For the transition year, CMS will automatically provide 3 points for quality measures that are submitted, regardless of whether they lack a benchmark or do not meet the case minimum or data completeness requirements. Zero points will be awarded only if the clinician fails to submit data on a required measure. Points are awarded based on the methodology described below; bonus points are available for reporting high priority measures.

Quality Measure Benchmarks

Measure-specific benchmarks will be computed based on performance during the baseline period. Baseline performance data will be divided into deciles (benchmarks), and an eligible clinician's points for a performance period will be assigned based on where it falls among these baseline period benchmarks. If baseline data are not available for a measure, or if the measure specifications have changed substantially since the baseline period, then the decile-based benchmarks will be determined using performance period data. In order to calculate a benchmark for a measure, CMS will require a minimum of 20 MIPS eligible clinicians meet the case minimum criteria and data completeness requirements for the measure to have a performance greater than zero. Data used will be from MIPS eligible clinicians and comparable APM data, including data from QPs and partial QPs. Benchmarks will be published prior to the start of the performance period or as soon as possible thereafter.

CMS will create separate benchmarks by submission mechanisms that do not have comparable measure specifications: EHR, claims, QCDR, qualified registry, CAHPS vendor submission, CMS Web interface, and administrative claims-based measures. For CMS Web Interface reporting, CMS will use the benchmarks from the corresponding reporting year of the Medicare Shared Savings Program (MSSP). Using the MSSP benchmarks, the MIPS method of assigning 1 to 10 points to each measure will be used. All scores below the 30th percentile (for which MSSP creates no benchmarks) will be assigned a value of 3 points in the transition year, as part of the global 3 point floor for measures.

CMS will exclude from the benchmark calculation data from eligible clinicians who report measures with a performance rate of 0 percent.

CMS modifies its policy from the proposed rule regarding how to calculate the benchmark when a measure is new or CMS cannot calculate a benchmark using historical data. The final policy will employ a 3-point new measure floor for new measures and measures without a benchmark based on baseline period data. This floor is finalized as an underlying policy, in contrast to the global 3-point floor CMS is adopting for all quality measures in the transition year. CMS believes that the 3-point floor for new measures would generally apply for the first two years a measure is in use until baseline data are available.

Assigning Achievement Points

CMS finalizes the decile scoring method for assigning points, but for the transition year it added a 3-point floor for all submitted measures, as well as the readmission measure (if the readmission measure is applicable). This means that MIPS eligible clinicians will receive between 3 and 10 points for each reported measure. Zero points will be awarded only if the clinician fails to submit data on a required measure.

Once decile benchmarks are calculated using performance from the baseline period or the performance period, CMS finalizes its proposal to assign up to 10 points for a measure based on which benchmark decile range the MIPS eligible clinician's performance rate on the measure falls between. For example, eligible clinicians in the top decile would receive 10 points for the measure, and MIPS eligible clinicians in the next lower decile would receive points ranging from 9 to 9.9. CMS finalizes assigning partial points to prevent performance cliffs for eligible clinicians with measure scores near the decile breaks. Table 17 in the proposed rule (81 *FR* 28252) is shown below and modified to reflect the final rule policy. It illustrates for a sample quality measure how decile achievement points will generally be assigned, reflecting the final rule policy establishing a global 3-point floor for each submitted measure during the transition year. In this example, for the illustrative Table 17 measure, an eligible clinician with a measure performance rate of 41 percent will receive 6.0 points; those with a rate of 85 percent or more will receive the maximum 10 points. During the transition year any eligible clinician who reported on this sample measure will receive at least 3 points, even if the case minimum was not met or the measure has no benchmark. A zero score is only awarded for a required measure that is not submitted.

Example of Using Benchmarks for a Single Measure to Assign Points*

Decile	Sample Quality Measure Benchmarks	Possible Points
Benchmark Decile 1	0-6.9%	3.0 in transition year 1.0-1.9
Benchmark Decile 2	7.0-15.9%	3.0 in transition year 2.0-2.9
Benchmark Decile 3	16.0-22.9%	3.0-3.9
Benchmark Decile 4	23.0-35.9%	4.0-4.9
Benchmark Decile 5	36.0-40.9%	5.0-5.9
Benchmark Decile 6	41.0-61.9%	6.0-6.9
Benchmark Decile 7	62.0-68.9%	7.0-7.9
Benchmark Decile 8	69.0-78.9%	8.0-8.9
Benchmark Decile 9	79.0-84.9%	9.0-9.9
Benchmark Decile 10	85.0%-100%	10

* Table is modified from Table 17 in the proposed rule (81 *FR* 28252).

The CAHPS score will be the average number of points across summary survey measures.

CMS delays implementation of any scoring modification for “topped out” measures (those for which performance shows little variation and is clustered at the top end) until the second year the measure has been identified as topped out. Therefore, for the transition year (2017 performance period), no topped out measures will be subject to modified scoring, as this is the first year that

any measure could be identified as topped out. CMS will identify topped out measures based on the baseline period, and this information will be posted along with the measure specifications and benchmarks prior to the start of the performance period.

Case Minimum Requirements

CMS establishes a case minimum of 20 cases for all quality measures, with the exception of the all-cause hospital readmissions measure, which has a minimum of 200 cases. However, the readmission measure will not apply to solo practices or small groups (those with 15 or fewer clinicians) or the MIPS individual reporters.

Except for CMS Web Interface measures and administrative claims-based measures, eligible MIPS clinicians that report measures with fewer than 20 cases during the transition year will receive an automatic score of 3 points. The 3-point floor will also apply when data completeness requirements are not met and when the measure is one for which a benchmark cannot be calculated.

For CMS Web Interface measures, a clinician that submits a measure that does not meet the required case minimum or for which there is no benchmark will receive recognition for submitting the measure, but it will not be included in the quality performance category score. Measures submitted that do not meet the data completeness requirement, however, will be given a score of zero. As a general policy, not just for the initial transition year, administrative claims measures for which the case minimum is not met or for which a benchmark cannot be calculated will not be included in the clinician's score. For the transition year, the readmission measure is the only administrative claims-based quality measure.

Table 17 in the final rule, reproduced below, summarizes the scoring rules for the transition year (2017 performance period). For purposes of discussion, the measures are identified in the table as Class 1 or Class 2 based on whether the measure can be scored based on performance. (That is, a benchmark can be calculated and the case minimum and data completeness requirements are met. Note that a benchmark can be calculated when there are at least 20 reporters with at least 20 cases that meet data completeness requirements and have a performance score greater than zero.)

CMS further finalizes it will exclude Class 1 measures from scoring if it identifies issues or circumstances that would impact the reliability or validity of a measure score. In the transition year the 3-point floor will apply to these measures if they are submitted. For Web Interface and administrative claims-based measures the 3-point floor will not apply and the measure will be excluded from scoring. The final rule provides several numerical examples of how the scoring would work.

TABLE 17: Quality Performance Category: Scoring Measures Based on Performance for Performance Period 2017

Measure Type	Description	Scoring Rules
Class 1 – Measure <u>can be scored</u> based on performance	Measures that were submitted or calculated that met the following criteria: 1. The measure has a benchmark; 2. Has at least 20 cases; and 3. Meets the data completeness standard (generally 50 percent)	• Receive 3 to 10 points based on performance compared to the benchmark.
Class 2 – Measure <u>cannot be scored</u> based on performance and is instead assigned a 3-point score	Measures that were submitted, but fail to meet one of the class 1 criteria. Measures either 1. Do not have a benchmark, 2. Do not have at least 20 cases, or 3. Does not meet data completeness criteria	• Receive 3 points • Note: This Class 2 measure policy does not apply to CMS Web Interface measures and administrative claims-based measures

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

CMS will only give a zero score if a clinician fails to report a measure required to satisfy the quality performance category submission criteria. Clinicians will be given some amount of points for all measures that are successfully reported; a global 3-point floor for quality measures will be effective in the transition year.

Incentives to Report High Priority Measures

CMS finalizes scoring adjustments intended to encourage eligible clinicians to submit certain high priority measures. High priority measures are defined as outcome, appropriate use, patient safety, efficiency, patient experience and care coordination measures. They are listed in the Tables A-D in the Appendix.

Specifically, two bonus points will be provided for each outcome and patient experience measure and one bonus point for other high priority measures reported in addition to the one that would already be required under the quality performance category criteria. For example, if an eligible clinician submits two outcome measures, and two patient safety measures, he or she will receive two bonus points for the second outcome measure reported (not for the first, which would be required) and two bonus points for the two patient safety measures. MIPS eligible clinicians will only receive bonus points if they submit a high priority measure with a performance rate that is

greater than zero, provided the measure meets the case minimum data completeness requirements. Bonus points will be awarded for a measure that is not scored as long as the case minimum and data completeness requirements were met.

For groups reporting through the CMS Web Interface, bonus points will be based on the finalized set of measures reportable through that submission mechanism. Table 21 in the final rule lists the finalized quality measures available for reporting through the CMS Web Interface and indicates which measures are high priority measures.

Bonus points for high priority measures will be capped at 10 percent of the denominator of the quality performance category score.

Incentives to Use CEHRT

CMS will award one bonus point under the quality performance category score, up to a maximum of 10 percent of the denominator of the quality performance category score, if requirements for “end-to-end electronic reporting” are met. (The proposed cap was 5 percent.) Specifically, the bonus will be awarded for a measure if:

- CEHRT is used by the eligible clinician to record the measure’s demographic and clinical data elements in conformance to the standards relevant for the measure and submission pathway, including but not limited to the standards included in the CEHRT definition;
- The measure data is exported and transmitted by the eligible clinician electronically to a third party using relevant standards or directly to CMS; and
- The third party intermediary (for example, a QCDR) uses automated software to aggregate measure data, calculate measures, perform any filtering of measurement data, and submit the data electronically to CMS in accordance with data submission requirements.

This bonus will be in addition to the high priority bonus; separate bonus caps apply to each.

The CEHRT bonus for end-to-end electronic submissions will be available under all submission mechanisms except claims submissions (this means qualified registries, QCDRs, EHR submission mechanisms, and the CMS Web Interface), and will also be available for MIPS APMs reporting through the CMS Web Interface. For Web Interface users, end-to-end electronic reporting applies to cases where users upload data that has been electronically exported or extracted from EHRs, electronically calculated and electronically formatted into a CMS-specified file that is then electronically uploaded via the web interface, and not to cases where measures are entered manually into the CMS Web Interface.

Table 18 in the final rule includes examples of how end-to-end electronic reporting via various submission mechanisms (EHR data submission, third-party intermediary, QCDR) do or do not not qualify for the bonus. Examples where manual abstraction or manual entry is used at some point in the process do not receive the end-to-end reporting bonus.

Calculating the Quality Performance Category Score

The sum of the weighted points assigned to measures required by the quality performance category criteria would be added to any bonus points earned. That total would be divided by the weighted sum of total possible points to equal the quality performance category score. The quality performance category score cannot exceed the total possible points for this category.

If an eligible clinician reports more than the minimum number of measures, it would include in the category total only the scores for the measures with the highest assigned points once the first outcome (or other high priority measure) is scored. Reporting more than the minimum measures allows eligible clinicians to gain experience reporting measures before they are included in the score. It also provides a foundation for the clinician to gain improvement points in future years.

A clinician who does not have any scored measures will not have a quality performance score calculated, but CMS notes that in the transition year, clinicians who are not CMS Web Interface users who submit some quality data will have a score because of the application of the 3-point floor. Specifically, 3 points will be awarded for submitted measures that do not meet the case minimum or do not have a benchmark or do not meet data completeness requirements (even if the performance rate is zero) and at least 3 points will be awarded for measures that meet the case minimum, have a benchmark, and meet data completeness requirements where a performance rate is calculated, even if the performance rate is zero.

An example of the scoring methodology is presented in Table 19, which is reproduced here. In this example an eligible clinician in a group of 25 has submitted as a group via registry three process measures, one outcome measure, and one other high priority measure and one process measure that is below the case minimum. The maximum number of possible points in this example is 70 points. Based on performance, the clinician has earned 49.9 points. One bonus point is awarded for reporting an additional high priority patient safety measure and three bonus points are awarded for end-to-end electronic reporting. The quality performance category score for this MIPS eligible clinician is $(49.9 \text{ points} + 4 \text{ bonus points} = 53.9) / 70 \text{ total possible points} \times 60 \text{ (quality performance category weight)} = 46.2 \text{ points toward the final score}$. The quality performance category score is capped at 100 percent.

TABLE 19: Quality Performance Category Example with High Priority and CEHRT Bonus Points

Measure	Measure Type	Number of Cases	Points Based on Performance	Total Possible Points	Quality Bonus Points For High Priority	Quality Bonus Points for CEHRT
Measure 1	Outcome Measure using CEHRT	20	4.1	10	0 (required)	1
Measure 2	Process using CEHRT	21	9.3	10	N/A	1
Measure 3	Process via CEHRT	22	10	10	N/A	1
Measure 4	Process	50	10	10	N/A	N/A
Measure 5	High Priority-Patient Safety	43	8.5	10	1	N/A
Measure 6	Process below case minimum	10	3		N/A	N/A
All-Cause Hospital Readmission	Claims	205	5	10	N/A	N/A
Total Points	All Measures	N/A	49.9	70	1	3

Additional examples are provided in the final rule. Table 20 in the final rule illustrates how to calculate the bonus caps for the high priority quality performance category bonus cap and the CEHRT bonus.

CMS Web Interface Reporters

For CMS Web Interface reporters, instead of scoring the top six measures, all applicable measures are scored. If the group does not meet the reporting requirements for a measure, it will receive a zero score for that measure. That includes measures that are not reported and those below the data completeness requirements, as CMS believes Web Interface reporters are more experienced and should have no challenges in meeting data completeness requirements. CMS notes that most of the required measures for these groups are high priority measures so they would receive bonus points if all measures are reported as required. During the transition year, the 3-point global floor will apply, even to measures with a zero performance rate, if they meet

case minimums and data completeness requirements. Measures will not be scored if they are submitted but the case minimum requirement is not met. Measures with performance below the 30th percentile will be assigned 3 points during the transition year because the MSSP does not publish benchmarks below the 30th percentile. Table 22 in the final rule shows how the decile scoring will work for Shared Savings Program benchmarks.

Table 21 in the final rule shows the final quality measures available for MIPS Web Interface reporting in performance year 2017, which includes 13 individual measures and a two-part diabetes composite measure. CMS notes, however, that 3 of the measures do not have a benchmark in the Shared Savings Program and therefore will not be scored. As a result, while all the measures must be reported, 10 individual measures plus the diabetes composite will be used for scoring in 2017.

Table 23 in the final rule, shown below, compares the scoring approaches for Web Interface and other measures.

TABLE 23: Comparison of Scoring Approach of Web Interface and Non-Web Interface Measures

Data completeness, with/without case minimum criteria met/benchmark	Range of possible scores per measure for non-CMS Web Interface users	Range possible scores per measure for CMS Web Interface Users
No measures reported regardless of case minimum criteria met	0	0
No measures reported regardless of whether there is a benchmark	0	0
Partial data (below data completeness criteria requirement) without case minimum criteria met, regardless of whether the measure is at 0% performance rate or not	3	0
Partial data (below data completeness criteria requirement) without a benchmark, regardless of whether the measure is at 0% performance rate or not	3	0
Complete data (data completeness criteria met) without case minimum criteria met, regardless of whether the measure is at 0% performance rate or not	3	Null: The measure will not be scored
Complete data (data completeness criteria met) without a benchmark, regardless of whether the measure is at 0% performance rate or not	3	Null: The measure will not be scored

Complete data (data completeness criteria met) with case minimum criteria met, the measure has a benchmark, and the measure is at 0% performance rate	3	3
Complete data (data completeness criteria met) with case minimum criteria met, the measure has a benchmark, and the performance rate is greater than 0% performance rate**	3–10	3–10*
*SSP benchmarks start at the 30 th percentile ** Reflects the global 3-point floor for low performance, a measure that would have received 1 point or 2 points will now receive a score of 3 points.		

Measuring Improvement

In the first year of MIPS, no improvement points will be awarded.

c. Scoring the Cost Performance Category

CMS finalizes a zero weight for the cost performance category for 2019 MIPS payment; 10 percent for 2020 and 30 percent for 2021 and later years. The specific measures for this category are modified from the proposed rule to include only those that have previously been used in the VM or in the 2014 sQRUR.

In general, scoring of measures in the cost performance category is similar to scoring of measures in the quality performance category: benchmarks will be calculated as deciles and from 1 to 10 achievement points awarded depending on where the clinician's performance falls within the benchmarks. The measure scores will be averaged and then divided by the total number of potential points to determine the clinician's cost performance category score.

Cost Measure Benchmarks

Unlike the measures in the quality performance category, for the cost measures CMS will use data from the performance period to calculate the benchmarks rather than using performance from an earlier baseline period. A specialty adjustment will be applied to the total per capita cost measure but no further differentiation by specialty will be made.

Similar to the quality performance category, a minimum of 20 MIPS eligible clinicians (TIN/NPI combinations) or groups meeting the case minimum is required to calculate benchmarks for a measure. A measure that fails to meet this requirement will not be included in scoring for the cost performance category.

Assigning Points Based on Achievement

Lower costs represent better performance, so that in assigning achievement points, eligible clinicians in the top decile are those with the lowest costs. Table 25 in the final rule (not shown here) provides an example of the deciles and points for the cost category.

Case Minimum Requirements

A 20 case minimum will apply for each cost category measure, except that a 35 case minimum is adopted for the Medicare Spending per Beneficiary measure.

Calculating the Cost Performance Category Score

To calculate the final score, CMS will average the scores of all the category measures, weighting them equally. If an eligible clinician has a score for only one measure, that score becomes the category score. No cost performance score will be applied to a clinician for whom no cost measure is attributed, if the case minimums are not met, or because benchmarks are not calculated for the measures applicable to the clinician or group.

As with the quality performance category scoring, the cost performance category score is calculated as a percentage of the maximum possible points for the eligible clinician or group. Table 22 in the proposed rule (81 *FR* 28261) provides an example of how the cost category score would be calculated; this table is not included in the final rule.

d. Scoring the Improvement Activities Performance Category

For this performance category, CMS notes that the statute requires specific scoring rules. In particular, a MIPS eligible clinician who practices in a certified PCMH or comparable specialty practice for a performance period must receive the highest potential score for the improvement activities category. Further, eligible clinicians participating in an APM for a performance period must receive a score equal to at least one half of the highest potential score for the category.

Further, CMS notes that because this category has not been in place in prior programs, for the MIPS first year it cannot assess how well a clinician has performed on an activity relative to a baseline year, only whether the clinician has participated sufficiently to receive credit for the improvement activities category.

Assigning Points to Improvement Activities

CMS reduces the number of activities required to achieve the maximum score for this category. Activities will be divided into two categories: medium-weighted activities worth 10 points each and high-weighted activities worth 20 points each. However, the maximum points for this category will be 40 points, requiring reporting of four medium-weighted activities or two high-weighted activities or an equivalent combination (1 high-weighted, 2 medium-weighted). If a MIPS eligible clinician, other than a MIPS APM or APM does not select any activity, he or she will receive zero points in the improvement activities performance category.

For clinicians in a top performing small practice (15 or fewer professionals), a practice in a rural or health professional shortage area, or a non-patient-facing eligible clinician the points are doubled, and they can therefore achieve the maximum points for this category by reporting on one high-weighted or two medium-weighted activities.

Table H provided in an Appendix to the final rule provides the final improvement activities inventory. It lists 93 activities; 14 are high-weighted and 79 are medium-weighted activities. This list has been modified from the proposed rule. Table 26 in the final rule lists the high-weighted activities, and CMS notes in particular changes from this list as it was published as Table 23 in the proposed rule.

CMS finalizes its proposal that APM participants will receive at least one-half of the highest possible score for the improvement activities performance category. To develop the improvement activities score assigned to all MIPS APMs, CMS will compare the requirements of the specific APM with the list of activities in the improvement activities inventory (Table H) and score those activities in the same manner that they are scored for MIPS eligible clinicians (discussed above in section II.B.5.g).

Highest Potential Score

As discussed above, CMS finalizes 40 points is the highest potential score for the improvement activities category.

CMS notes that the intent of the improvement activities category is to show improvement over time, and that it may in the future adjust the weighting of improvement activities based on initial patterns of reporting. For example, a MIPS eligible clinician may not be allowed to continue to select the same activities for reporting year after year.

Points for Patient-Centered Medical Home or Comparable Specialty Practice

CMS will assign the maximum 40 points to a MIPS eligible clinician who is in a practice that is certified as a PCMH or comparable specialty practice or are a Medicaid Medical Home or Medical Home Model, or comparable specialty practice.

CMS finalizes an expanded definition of organizations that can certify practices as a PCMH or comparable specialty practices.

e. Calculating the Final Score

To calculate a final score, CMS will take the scores for each of the four performance categories, multiply them by the weight assigned to that category, sum those weighted scores and then multiply that sum by 100. Final scores will range from 0 to 100. The same identifier would be used for all four categories, and therefore the calculation methodology is the same for individual and group performances. Table 29 reproduced below shows the final performance category weights for the MIPS payment years 2019-2021. The weights were changed from the proposed

rule to reduce the cost category weight to zero in 2019 (from proposed 10 percent) and 10 percent in 2020 (from proposed 15 percent) and the difference was added to the quality category.

TABLE 25: Final Weights by Performance Category

Performance Category	2019 MIPS Payment	2020 MIPS Payment Year	2021 MIPS Payment Year and beyond
Quality	60%	50%	30%
Cost	0%	10%	30%
Improvement Activities	15%	15%	15%
Advancing Care Information*	25%	25%	25%
*The weight could decrease (not below 15 percent) if the Secretary estimates that the proportion of physicians who are meaningful EHR users is 75% or more. Remaining weights will be reallocated to other performance categories.			

Flexibility in Weighting Performance Categories

Under the final rule, CMS will maintain a consistent weight for the quality performance category and will score all measures that are submitted or calculated for a clinician. Required measures that are not submitted will receive a score of zero points. CMS believes this approach is simpler than what was proposed and will encourage eligible clinicians to participate in MIPS and report quality data.

Specifically, CMS does not adopt its proposal that if an eligible clinician has fewer than three scored quality measures for a performance period, the weight of the quality performance category would be reduced and redistributed proportionately among the categories for which the clinician is scored. However, if a MIPS eligible clinician has no scored measures for the quality category for the transition year (which CMS believes to be an unlikely scenario because of the global 3-point minimum score adopted in this final rule), CMS finalized it will reduce the quality category weight to zero for that clinician and redistribute the weight among the other categories, as described below.

Redistribution of Performance Category Weights

CMS finalizes a modification of its proposal for redistributing category weights. When no performance score can be assigned for the ACI or quality categories, CMS proposed to redistribute the category weights for the transition year as shown in Table 30, which is reproduced below.

**TABLE 30: Performance Category Redistribution Policies for the Transition Year
(MIPS payment year 2019)**

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

7. MIPS Payment Adjustments

The MIPS adjustment factor will be applied to Part B payments as a percentage adjustment for a payment year. Part B amounts otherwise payable would be multiplied by 1 plus the MIPS adjustment percentage.

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

CMS finalizes its proposal to apply the MIPS payment adjustment using the single identifier TIN/NPI, regardless of whether performance is measured as an individual, group identified by TIN, or APM Entity group. CMS offered two reasons in support of this approach. First, the final eligibility status of some clinicians would not be known until after the performance period ends. Second, the identifiers for measurement are not mutually exclusive and using the TIN/NPI to apply the payment adjustment allows CMS to resolve inconsistencies among the measurement identifiers.

TIN/NPIs participating in a group practice or APM will generally have the same final score and the same payment adjustment, except when (1) a TIN/NPI is excluded from MIPS, (2) a TIN/NPI has multiple possible final score submissions (i.e., APM Entity final score and a TIN final score); or (3) the TIN/NPI is new to a TIN or a TIN is new and therefore there is no historical data associated with the TIN/NPI.

For groups submitting data using the TIN identifier, the group final score will be applied to all the TIN/NPI combinations that bill under that TIN during the performance period. For individual clinicians submitting data using TIN/NPI, the final score will be 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 the APM Entity Participant Identifiers associated with the APM Entity. For eligible clinicians that participate in APMs for which the APM scoring standard does not apply, the final score will be assigned using either the individual or group assignments.

In cases where for a payment period a clinician switches practices or otherwise establishes a new TIN that did not exist during the performance period, CMS will use the NPI's performance for the TIN the NPI was billing under during the performance period. Responding to concerns about placing a burden on the hiring entity, CMS says that the TIN will not perform any calculations. CMS will apply the appropriate payment adjustment to the TIN/NPI for the payment year.

b. MIPS Payment Adjustment Factors

If a clinician billed under more than one TIN during the performance period, the highest final score associated with the NPI will be assigned.

The statute provides that the MIPS adjustment factor be calculated so that eligible clinicians with a final score at or above the performance threshold receive a zero or positive adjustment factor. The adjustment of 0 percent is assigned for a final score at the performance threshold and a maximum adjustment factor of the “applicable percent” (4 percent for 2019) is assigned for a final score of 100 percent; a linear sliding scale determines the adjustment for a final score that falls between these amounts.

For eligible clinicians with a final score below the performance threshold, the MIPS adjustment factor is negative, with the maximum negative adjustment of the applicable percent assigned to a final score equal to or greater than zero but not greater than one-fourth of the performance threshold. A linear sliding scale between the maximum negative adjustment and the threshold adjustment of zero determines the negative adjustment for a final score between these amounts. The “applicable percent” amounts are 5 percent for 2020, 7 percent for 2021 and 9 percent for 2022 and later years.

For payment years 2019 through 2024, an additional positive adjustment is provided for exceptional performance, defined as having a final score that is above the additional performance threshold. For each of those years the statute provides \$500 million to be distributed among clinicians achieving performance above the additional performance threshold. The maximum additional adjustment factor that a clinician may receive is 10 percent; this cap may result in less than \$500 million being distributed.

c. Performance Threshold

Based on significant concerns of commenters that clinicians do not have time to prepare for MIPS, CMS finalized that 2019 payment year will be a transition year and modifies the final performance threshold from what it had proposed. Under the proposed rule CMS would have set the performance threshold so that half of eligible clinicians would fall above it (positive payment adjustment) and half below it (negative payment adjustment). CMS agrees with commenters that setting the performance threshold at an appropriately low number during the transition year will permit clinicians to gain experience with the program. Therefore, it is using authority under section 1848(q)(6)(D)(iii) of the Act to establish the performance threshold for the first two years of the MIPS based on a period prior to the performance period.

Referencing available data on PQRS performance and other data sources, CMS sets the performance threshold at 3 points for the 2019 MIPS payment year. At this level, a clinician can meet or exceed the performance threshold through a minimal level of performance, such as receiving the 3-point floor for a single submitted quality measure. With that score the clinician could avoid a negative adjustment without submitting any measures in the ACI or improvement activity categories. A solo practitioner submitting a single improvement activity will receive at least 7.5 points. However, CMS notes that a clinician reporting only on the ACI category and not on the quality or improvement activity categories will need to report on all the measures in the base score to avoid a negative adjustment (discussed above in section II.B.5.f). Scaling/Budget Neutrality

The statute requires that MIPS adjustments (excluding additional adjustments) generally be budget neutral so that the increase in aggregate allowed charges resulting from positive MIPS adjustments equals the estimated decrease resulting from the application of negative adjustments. Budget neutrality does not apply if all eligible clinicians for a year receive a negative adjustment or if the maximum scaling factor of 3.0 is applied. To this end, MIPS adjustments for clinicians with scores above the threshold (a positive adjustment) must be increased or decreased by a scaling factor (not to exceed 3.0). CMS notes that by setting a low performance threshold for the transition year, relatively few clinicians will receive a negative adjustment and therefore the amount available for positive adjustments will also be limited.

CMS intends to increase the performance threshold of the MIPS for the 2020 payment year and beginning with 2021 will use the mean or median final score from a prior period as required by statute. It notes that the numerical threshold may not be published in the final rule, but instead the methodology will be finalized in the final rule and the numerical threshold announced on a website prior to the performance period.

Additional Adjustment Factors

MACRA requires for 2019 through 2024, an additional adjustment factor to determine whether a MIPS eligible clinician qualifies for an additional positive adjustment factor for exceptional performance. CMS finalizes the additional adjustment factor (or “incentive payment”) will be calculated by applying a linear scale factor between 0 and 1.0 from the additional performance threshold and a final score equal to the maximum score of 100. The incentive payment adjustment will be 0.5 percent at the additional performance threshold and 10 percent at the maximum score. A scaling factor will be applied to ensure distribution of the \$500 million in aggregate incentive payments. Because the additional adjustment is capped at 10 percent, the result may be that an amount less than \$500 million may be distributed. CMS may lower the 0.5 percent starting point if necessary to meet the constraints of distributing the \$500 million and maintaining a linear scale between 0 and 1.0.

The final additional performance threshold is 70. A final score of 70 will 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.

8. Review and Correction of the Final Score

CMS finalizes processes for performance feedback to eligible clinicians and APM entities, announcement and review of adjustments for a payment year, and data validation and auditing.

a. Performance Feedback

CMS will use the QRUR released on September 26, 2016 (the 2015 Annual QRUR) as the first MIPS performance feedback. MIPS eligible clinicians without data included in the September 2016 QRUR will not receive performance feedback until it is able to use data acquired through the QPP for performance feedback.

The September 2016 QRURs may be accessed at <https://portal.cms.gov/wps/portal/unauthportal/home/>. CMS notes that the QRURs are produced at the TIN level because this is the level at which the VM is applied. CMS intends to provide as much feedback as technically possible to clinicians at the individual level prior to the 2018 performance period. It is looking into providing feedback on claims-base cost data and claims-based outcome measures.

For the 2016 Annual QRUR anticipated in fall 2017, CMS will show how groups and solo practitioners performed in 2016 on the cost and quality measures used to calculate the 2018 VM. This will be the last annual QRUR as the VM is sunseting. By the summer of 2018 CMS expects to make available feedback on 2017 performance, including the cost and quality categories, the final score and payment adjustment.

b. Announcement of MIPS Adjustments

CMS must make the payment adjustment applicable to an eligible clinician available to them no later than 30 days prior to January 1 of the payment year. If technically feasible CMS will include the MIPS adjustment as part of the performance feedback. The first such announcement must be made by December 1, 2018. CMS will announce through guidance documents or other program communication channels as to when and how this information will be announced prior to the statutory deadline of December 1, 2018. In future years of the program, CMS intends to make performance feedback available via a web-based application, including the MIPS adjustment.

c. Targeted Review of MIPS Adjustments

CMS finalizes the following targeted review 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.

- No hearing process will be included as this process is informal and the statute does not require a formal appeals process.
- 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.

If a request for targeted review is approved, the outcome of the review may vary, resulting in exclusion from MIPS, redistribution of category weights and recalculating the final score, or recalculating a performance category score in accordance with the scoring methodology.

The statute prohibits administrative and judicial review of the methodologies used to calculate performances and determination of the MIPS adjustment factor, the establishment of performance standards and performance periods, and identification of measures and activities specified for a performance category.

d. Data Validation and Auditing

CMS finalizes it 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.

CMS will monitor MIPS eligible clinicians and groups on an ongoing basis for data validation, auditing, program integrity issues and instances of non-compliance with MIPS requirements. If an eligible clinician or group is found to have submitted inaccurate data for MIPS, CMS finalizes it will reopen, revise, and recoup any resulting overpayments in accordance with existing rules.

Finally, all MIPS eligible clinicians and groups that submit data to CMS electronically must attest to the accuracy and completeness to the best of their knowledge of any data submitted.

CMS states that audit documentation will be addressed with eligible clinicians and groups that are selected for audit. Instructions for completing the audit and examples of documents required will be provided during the initial notice. MIPS eligible clinicians and groups should retain copies of medical records, charts, reports and any electronic data utilized to determine which

measures and activities were applicable and appropriate for their scope of practice and patient population for MIPS reporting for up to 10 years after the conclusion of the performance period.

CMS intends to thoroughly review all errors that are identified during data validation with careful consideration given to inadvertent and episodic data entry errors. CMS states that resubmission of data for recalculation during an audit is not currently technically feasible. Requests for recalculation for data errors will require a targeted review request, which will operationally occur before an audit and data validation process begins. CMS notes that during the transition year, data from other payers will be used for informational purposes to improve future validation efforts.

9. Public Reporting on Physician Compare

Under the finalized provisions, Physician Compare will include:

- For each MIPS eligible clinician, composite scores and performance by category; and
- Aggregate information on the range of MIPS composite scores and range of performance by category.

These data will be added on the profile pages or in the downloadable database, as technically feasible.

All MIPS quality performance category measures reported for individual clinicians and groups via all submission methods will be available for public reporting on Physician Compare. Consistent with current policy, not all measures will be made available on the consumer-facing website pages. All measures that meet the public reporting standards will be included in the downloadable database, and a subset chosen for reporting on the website. First year measures will not be publicly reported.

CMS will move to a reliability threshold approach for including data on the website instead of continuing the current minimum sample size of 20 patients. Data for each measure will be subject to statistical analysis to determine the minimum reliability threshold, and the performance rate for a clinician or group will only be publicly reported if the minimum threshold is met. The total number of patients reported on a measure will also be included in the downloadable database.

With respect to the resource use category, CMS reiterates that it has found that resource use data are not well understood by consumers, and finalizes as proposed including on Physician Compare a subset of resource use measures selected using statistical testing and consumer testing. First year measures will not be reported and new measures will be evaluated to determine if they are suitable for public reporting.

All CPIA category data will be available for public reporting on Physician Compare. CMS will identify a subset of data that meet public reporting standards. An indicator that a clinician has successfully met CPIA category requirements may be posted.

With respect to the advancing care information category, CMS expands the information provided on Physician Compare regarding clinicians' performance on measures of meaningful use. Currently, a green check mark on the profile page indicates that an EP has successfully participated in the EHR Incentive Program. To the extent it is feasible, and subject to statistical testing and consumer testing, CMS will include an indicator for any eligible clinician or group that successfully meets the advancing care information performance category. CMS will continue plans finalized in previous rulemaking to include utilization data in the Physician Compare downloadable data base beginning in late 2017.

With respect to APM data, CMS will indicate on the profile pages when an eligible clinician or group is participating in an APM, and will provide links to APM data for both Advanced and other APMs that are not considered Advanced APMs. CMS notes that APMs are a new concept for consumers and intends to test language for explaining the concept.

C. Incentive Payments in Advanced APMs

1. Background and Policy Principles

CMS reprises the key statutory elements of Section 1833(z) of the Act, as added by MACRA:

- Beginning in 2019, eligible clinicians can become Qualifying Participants (QPs) and be excluded from MIPS, based upon their extent of APM participation.
- For 2019 and 2020, the only pathway to QP status is through Advanced APM participation; all Advanced APMs are sponsored by CMS.
- For 2021 and beyond, QP status can be reached by combining Advanced APM with Other Payer Advanced APM participation.
- From 2019 through 2024, QPs receive a lump sum incentive payment annually equal to 5 percent of their prior year's payments for Medicare Part B covered professional services; beginning in 2026, QPs receive a higher annual fee schedule update than non-QPs.⁷

2. Terms and Definitions

CMS modifies, clarifies, and finalizes definitions for several key APM-related terms, detailed below. These terms are taken from a longer list that is unchanged from the proposed rule.⁸

a. APM Entity and Advanced APM Entity

An APM entity is defined as “an APM Entity that participates in an Advanced APM or Other Payer Advanced APM with CMS or a non-Medicare other payer, respectively, through a direct agreement with CMS or the payer or through federal or state law or regulation.”

b. Medical Home Model and Medicaid Medical Home Model

⁷ The “qualifying APM conversion factor” is set at 0.75% for QPs and 0.25% for non-QPs.

⁸ 81 FR 28172

Medical Home Model. Medical Home Model is defined as a subtype of APM and its associated medical home as an APM Entity.⁹ CMS further proposed two elements for the Medical Home Model that model participants must have:

- Model participants must include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
- Each patient cared for under the model must be empaneled to a primary clinician.

CMS also proposed that model participants must have at least four of the following seven elements:

- Planned chronic and preventive care coordination
- Patient access and care continuity
- Risk-stratified care management
- Care coordination across the medical neighborhood
- Patient and caregiver engagement
- Shared decision-making
- Payment arrangements beyond or in lieu of FFS payments (e.g., shared savings or population-based payments)

Medicaid Medical Home Model. CMS finalizes that the definition of a Medicaid Medical Home Model is identical to the finalized definition of a Medical Home Model (again with the substitution of a Title XIX payment arrangement for a Medicare APM framework).

c. Other Definitions

CMS finalizes as proposed the remaining terms and definitions listed in section II.F.3.a. of the final rule.

3. Advanced APMs

An APM is any one of:

- 1) a section 1115(A) model
- 2) The Medicare Shared Savings Program (MSSP)
- 3) A section 1866C demonstration, or a demonstration required by federal law.

To enhance clarity, CMS finalizes the following criteria for a demonstration required by federal law to be considered an APM:

- 1) The enacting law requires CMS to undertake the demonstration
- 2) The demonstration is structured to evaluate a thesis
- 3) Entities participating in the demonstration do so under a CMS agreement, statute, or regulation.

⁹ Relatedly, CMS notes that medical home expansion under section 1115A(c) of the Act means expansion of the medical home model (the APM), not the participating medical homes (the APM Entities).

Some APMs have multiple tracks/options; different tracks/options within a single APM may vary in structural elements that differentially impact their Advanced APM eligibility. CMS will independently assess each track or option for Advanced APM eligibility.

a. Advanced APM Determination

CMS finalizes without change the following proposals:

- CMS will release as soon as possible the initial Advanced APM list, no later than January 1, 2017. Note that CMS published a table on its website on October 14th that identified the list of Advanced APMs for 2017, though it's not clear whether this list is final.¹⁰
- An Advanced APM determination will be included in the initial public notice of each new APM (e.g., Request for Application).
- If changes to an APM affect its Advanced APM status, that status change will be included in the public notice updating the APM.
- All Advanced APM determinations will be posted on the CMS website; updates will be performed on an ad hoc basis but no less often than annually.
- All public notices will provide Advanced APM determinations for all tracks and options.

b. Advanced APM Criteria

CMS recalls the statutory criteria for an APM to be considered an Advanced APM, all of which must be satisfied:

- Participants are required to use Certified Electronic Health Record Technology (CEHRT).
- Payment for covered professional services must depend at least in part on quality measures comparable to those in the MIPS quality performance category.
- Participating APM Entities must bear risk for more than nominal monetary losses or be an expanded Medical Home Model (under section 1115A(c) of the Act).

These criteria are met through the design of the APM (e.g., one-sided versus two-sided risk), unrelated to how APM participants perform (e.g., whether the APM achieves savings or losses).

(1) CEHRT Use Advanced APM Criterion

An Advanced APM must require its participants to utilize CEHRT, as defined in section 1848(o)(4) of the Act and as specified in section 18233(z)(3)(D)(i)(I) of the Act.

(a) Defining CEHRT

CMS defines CEHRT identically under the MIPS and APM Incentive programs, based upon certification criteria from the Office of the National Coordinator for Health Information Technology (ONC). This allows either Modified Stage 2 (ONC 2014 Edition) or Stage 3 (ONC 2015 Edition) EHR criteria to be used in 2017, while Stage 3 criteria will be required beginning in 2018.

¹⁰ This list can be downloaded at https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf.

(b) Requiring CEHRT Use

CMS finalizes the eligible clinician 50 percent CEHRT use threshold for 2017 and 2018. It will address potential changes for 2019 through future rulemaking. APMs whose participants are hospitals must require the hospitals to use CEHRT to reach Advanced APM status and that the 50 percent rule does not apply to hospitals.

(c) Requiring CEHRT Use in the MSSP

Although MSSP ACOs must encourage technology use for care coordination, the MSSP does not specify a required level of CEHRT use nor directly condition payment on CEHRT use. CMS therefore finalized an alternative approach linking the amount of shared savings (or losses) earned by an MSSP ACO to its performance on CMS measure ACO-#11 *Percent of Primary Care Physicians Who Successfully Meet Meaningful Use Requirements*.¹¹ MSSP ACOs would submit ACO-#11 data for its eligible clinicians consistent with the specifications of that measure.¹²

(2) Comparable Quality Measures Criterion

The second statutory requirement for an Advanced APM is to provide payment for covered professional services based upon MIPS-comparable quality measures.¹³ As such:

- Advanced APMs must base payment on quality measures that are evidence-based, reliable, and valid.
- At least one quality measure must be an outcome measure, unless there is no outcome measure relevant to the Advanced APM on the MIPS quality measure list at the time the APM is developed.
- Measures that are not NQF-endorsed or on the MIPS measure list would undergo review through an internal Innovation Center process.

(3) Financial Risk for Monetary Losses

The third statutory requirement for an Advanced APM is for the APM to bear risk for more than nominal monetary losses or to be an expanded Medical Home Model (under section 1115A(c) of the Act).

(a) Bearing Financial Risk for Monetary Losses

(i) Generally Applicable Advanced APM Standard

An Advanced APM must include provisions that if the actual APM Entity expenditures exceed those expected during a specified performance period, then CMS can withhold payment for services to the APM Entity and/or its eligible clinicians; reduce payment rates to the APM Entity and/or its eligible clinicians; or require the APM Entity to owe payment(s) to CMS. The first two provisions apply to Advanced APMs with two-sided risk arrangements and the third allows

¹¹ The ACO-#11 measure information sheet can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-11.pdf>

¹² CMS will finalize ACO-#11 measure specifications in the forthcoming 2017 Physician Fee Schedule final rule.

¹³ MIPS quality measures are discussed in section II.E.3.b. of the final rule and previously in this summary.

retrospective reconciliation (e.g., episode-based bundled payment such as CJR). Reduction to payments guaranteed under the APM model (e.g., care management fees linked to quality performance) is not included as a CMS option, only the Medical Home option.

(ii) Medical Home Model Financial Risk Standard

For a medical home to be an Advanced APM, it must include the following provisions for when medical home actual expenditures exceed those expected or when APM Entity performance does not meet goals on specified measures. Under those circumstances, CMS can

- withhold payment for services to the APM Entity and/or its eligible clinicians;
- reduce payment rates to the APM Entity and/or its eligible clinicians;
- require the APM Entity to owe payment(s) to CMS; or
- cause the APM Entity to lose the right to some or all of an otherwise guaranteed payment or payments.

The above standard can only be applied to Medical Home Models that have been expanded, otherwise they are subject to the Generally Applicable Advanced APM Standard. Currently, no medical homes have been expanded under section 1115A(c) of the Act.

(4) Nominal Amount of Risk

APM Entities that are judged as bearing financial risk are then assessed as to whether their risk exposure is more than nominal (“the nominal amount standard”), which CMS defines quantitatively.

(a) Advanced APM Nominal Amount Standard

For 2017 and 2018, an APM may meet the standard in two ways:

- 1) “Revenue-Based” (the total annual amount potentially owed to CMS or forgone is ≥ 8 percent of the average estimated total Parts A and B revenues of participating APM Entities) or
- 2) “Benchmark-Based” (the owed or forgone amount is ≥ 3 percent of the expected expenditures for which an APM Entity is responsible under the APM; expected expenditures for episode payment models means the target price).

For 2019 and beyond, the benchmark-based standard will remain in force as finalized. The amount and structure of the revenue-based standard will be determined after the comment period for this final rule.

The nominal amount standard as finalized is for use in determining whether an APM is an Advanced APM; actual risk-bearing by APM participants is defined through the APM’s terms and conditions. Only those risk arrangements defined by the APM’s terms and conditions will be counted during risk assessment, not the underlying payment system(s) as modified by the APM (e.g., may include bundled payments but does not include FFS Medicare payments). Payments made “outside” of the risk arrangement also will not be counted toward the nominal amount standard (e.g., a uniform, upfront 1 percent discount on CMS payments to the APM

Entity). Episode payment models using a revenue-based nominal amount standard would be unlikely to satisfy standards for becoming Advanced APMs. Finally, CMS intends that a revenue-based nominal amount standard tailor the risk borne by an APM Entity to all the resources available to it, including those of its parent and subsidiary organizations.

(b) Medical Home Standard

CMS finalized without change the following Medical Home Model nominal amount standard for the minimum total amount potentially owed to CMS or forgone under the model:

- in 2017, 2.5 percent of the APM Entity's total Medicare Parts A and B revenue;
- in 2018, 3 percent of the APM Entity's total Medicare Parts A and B revenue;
- in 2019, 4 percent of the APM Entity's total Medicare Parts A and B revenue; and
- in 2020 and later, 5 percent of the APM Entity's total Medicare Parts A and B revenue.

To limit eligibility for this medical home standard to only those entities with truly limited risk-bearing capacity, CMS limits the medical home nominal amount standard to APM Entities having 50 or fewer eligible clinicians in the organization through which the APM Entity is owned and operated starting in 2018. In 2018 larger medical homes would be subject to the Generally Applicable Nominal Amount Standard, and medical homes that meet the generally applicable standard would not be subject to any organizational size limitations.

(5) Capitation

Full capitation arrangements meet the Advanced APM financial risk criterion since the capitated APM Entity bears full upside and downside risk.¹⁴ CMS differentiates capitation as a risk arrangement from capitation as a cash flow mechanism; the latter is not necessarily a full risk arrangement.¹⁵ Partial capitation arrangements would not qualify as meeting the APM financial risk criterion but some could meet the generally applicable nominal risk standard.

(6) Medical Home Expanded Under Section 1115A(c) of the Act

CMS recalls that Section 1833(z)(3)(D)(ii)(II) of the Act allows an APM to become an Advanced APM by meeting either the financial risk criterion or by being a Medical Home Model expanded under section 1115A(c) of the Act ("expanded Medical Home Model criterion"). Therefore, a Medical Home Model that has been expanded meets the expanded Medical Home Model criterion and be exempt from the Advanced APM financial risk criterion. Meeting the expanded medical home model criterion requires an APM both to be a Medical Home Model and to be expanded under section 1115A(c) of the Act.¹⁶ A Medical Home Model that meets the

¹⁴ CMS defines a capitation risk arrangement as a payment arrangement in which a per capita or otherwise predetermined payment is made to an APM Entity for all items and services furnished to a population of beneficiaries, and no settlement is performed for the purpose of reconciling or sharing losses incurred or savings earned by the APM Entity.

¹⁵ Under a capitation cash flow mechanism, payments are made to entities in predetermined amounts that are later reconciled or adjusted based on actual services. CMS provides an example in the final rule Section F.4.b.(5).

¹⁶ See Section II.F.3.b. of the final rule. Note that expansion of a model tested under section 1115A(b) of the Act is contingent upon whether: 1) the HHS Secretary determines that the expansion is expected to reduce spending without reducing care quality or to improve care quality without increasing spending; 2) the CMS Chief Actuary

expansion criteria but has not been formally expanded would not meet the Advanced APM financial criterion.

(7) Application of criteria to current and recently announced APMs

CMS published a table on its website that identifies the following seven APMs CMS anticipates will meet the criteria to be Advanced APMs for 2017.¹⁷

- Comprehensive ESRD Care (CEC) Model (Large Dialysis Organization arrangement)
- Comprehensive ESRD Care (CEC) Model (non- Large Dialysis Organization two-sided risk arrangement)
- Comprehensive Primary Care Plus (CPC+) Model
- Medicare Shared Savings Program—Track 2
- Medicare Shared Savings Program—Track 3
- Next Generation ACO Model
- Oncology Care Model (two-sided risk arrangement)

This table also identifies which APMs are “MIPS APMs” for 2017. CMS also notes that certain APMs are likely to be implemented in 2017 or 2018 but have design parameters that have not yet been finalized. This list includes:

- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT Track)
- Advancing Care Coordination through Episode Payment Models Track 2 (non-CEHRT Track)
- Cardiac Rehabilitation Incentive Payment Model
- Comprehensive Care for Joint Replacement (CEHRT Track)
- Medicare ACO Track 1+
- Medicare Diabetes Prevention Program

4. Qualifying and Partial Qualifying APM Participant

CMS finalizes a process for making QP or Partial QP status determinations for eligible clinicians participating in Advanced APMs. These determinations would be made during the year following the relevant performance year (e.g., in 2018 for performance year 2017/payment year 2019). Per statute, QP or Partial QP status is reached when an eligible clinician participates in an Advanced APM Entity that collectively meets pre-defined thresholds for Medicare payments or number of beneficiaries treated under the APM. QPs by statute receive incentive payments (lump sum bonus, higher PFS conversion factor update, exclusion from MIPS participation); Partial QPs do not receive incentive payments but may choose to be excluded from MIPS. Status determinations would be made annually and independently (without regard to results from prior years). Per statute, QP/Partial QP status is assessed using two distinct “options”; the

certifies that the expansion would reduce (or not increase) net program spending; and 3) the HHS Secretary determines that the expansion would not deny or limit beneficiary benefits or coverage.

¹⁷ See https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf. This appears to be the final list, but in a different part of its website CMS lists models it anticipates will be Advanced APMs and states that it will publish a final list before January 1, 2017.

Medicare option, available beginning in payment year 2019, and the All-Payer Combination option, available beginning in payment year 2021.¹⁸ CMS will calculate threshold scores for eligible clinicians then compare those scores to the corresponding threshold values for reaching QP/Partial QP status. CMS will calculate threshold scores using both options and applying the most favorable result to the clinician.

The Medicare Option QP and Partial QP thresholds using the payment and patient count approaches as shown in Tables 32 and 34 of the final rule. The analogous threshold values for the All-Payer Combination Option are shown in Tables 33 and 35.

TABLE 32—QP PAYMENT AMOUNT THRESHOLDS—MEDICARE OPTION

Medicare Option—Payment Amount Method						
Payment year	2019 (percent)	2020 (percent)	2021 (percent)	2022 (percent)	2023 (percent)	2024 and later (percent)
QP Payment Amount Threshold	25	25	50	50	75	75
Partial QP Payment Amount Threshold ..	20	20	40	40	50	50

TABLE 33: QP Payment Amount Thresholds – All-Payer Combination Option

All-Payer Combination Option – Payment Amount Method										
Payment Year	2019	2020	2021		2022		2023		2024 and later	
QP Payment Amount Threshold	N/A	N/A	50%	25%	50%	25%	75%	25%	75%	25%
Partial QP Payment Amount Threshold	N/A	N/A	40%	20%	40%	20%	50%	20%	50%	20%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

TABLE 34—QP PATIENT COUNT THRESHOLDS—MEDICARE OPTION

Medicare Threshold Option—Patient Count Method						
Payment year	2019 (percent)	2020 (percent)	2021 (percent)	2022 (percent)	2023 (percent)	2024 and later (percent)
QP Patient Count Threshold	20	20	35	35	50	50
Partial QP Patient Count Threshold	10	10	25	25	35	35

¹⁸ CMS notes that the term “options” is statutory but does not imply that clinicians may choose between the options.

TABLE 35: QP Patient Count Thresholds – All-Payer Combination Option

All-Payer Combination Option – Patient Count Method										
Payment Year	2019	2020	2021		2022		2023		2024 and later	
QP Patient Count Threshold	N/A	N/A	35%	20%	35%	20%	50%	20%	50%	20%
Partial QP Patient Count Threshold	N/A	N/A	25%	10%	25%	10%	35%	10%	35%	10%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

a. Group Determination and Lists

(1) Group Determination

CMS will, with two exceptions discussed below, make the QP and PQP determination at a group level (APM Entity). Data for all eligible clinicians participating in an Advanced APM Entity (their “group”) during a performance period would be aggregated for QP determination calculations.

Exceptions:

- 1) For an individual who participates in multiple Advanced APM Entities, none of whom reach QP threshold as a group; and
- 2) for individual clinicians on an entity’s Affiliated Practitioner List when that list is used for QP determination in the absence of a Participation List.

In the latter case, CMS perceives that the clinicians on an Affiliated Practitioner List are unlikely to have the same collaborative organizational interrelationships as shared by those on a Participation List. CMS rejects the use of TIN/NPI combination for QP status determinations, as a single clinician may have multiple TIN/NPI combinations; this could lead to an eligible clinician being subject to MIPS via one TIN/NPI combination and being excluded from MIPS via another TIN/NPI pairing.

(2) Groups Used for QP Determination

The group will include all eligible clinicians participating in an Advanced APM Entity during the performance period. CMS will define the group through the Entity’s Participation List; the Entity provides this list to CMS and each listed clinician is identified by a unique TIN/NPI combination. CMS also finalized exceptions for the following two situations:

- when the Participation List does not include eligible clinicians (e.g., as in CJR wherein hospitals are the APM participants)
 - CMS will perform individual QP status determinations using the APM Entity’s Affiliated Practitioner List, and

- when the APM has multiple types of participating APM Entities (e.g., as in BPCI, wherein group practices and hospitals may be APM participants) and those entities variably have Participation Lists, Affiliated Practitioner Lists, or both
 - For the entities with Practitioner Lists, QP determinations will be made at the group (entity) level based on Practitioner Lists; any co-existing Affiliated Practitioner Lists will not be used in the QP determination.
 - For the entities with only Affiliated Practitioner Lists, those lists will be used to make QP determinations for each individual clinician.

(3) Exception for Participation in Multiple APMs

CMS finalizes that:

- 1) if at least one of the Advanced APM Entities in which the clinician participates reaches QP status, then the clinician would be considered a QP; and
- 2) if none of the Advanced APM Entities in which the clinician participates reaches QP status, CMS will aggregate the clinician's APM data and perform a QP status determination at the individual level.

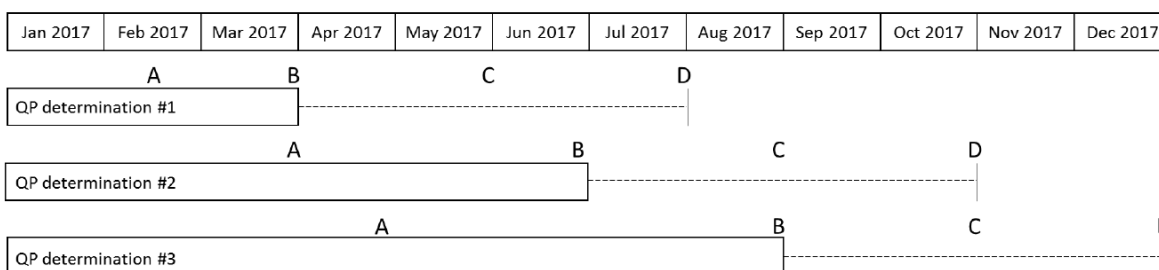
(4) Timing of Group Identification for Eligible Clinicians

CMS will take three snapshots annually for the purpose of making QP determinations: March 31, June 30, and August 31. The three snapshots are additive: eligible clinicians can be added to group list between snapshots but will not be removed from a group until after the final snapshot of each performance year. Once an eligible clinician is added to a Participation List (or Affiliated Practitioner List, as appropriate), and the group (or individual) reaches QP status, that QP determination remains in force until the end of the performance year for those eligible clinicians who were on the Participation List (or Affiliated Practitioner List) at the time of the snapshot that resulted in reaching QP status.

b. QP Performance Period

CMS finalizes a modified QP Performance Period and provides a summary graphic of the sequential performance periods and status determinations (Figure G, reproduced below from the final rule).

FIGURE G: QP Performance Period



A = claims data period used for QP determination; B = the snapshot date (Participation or Affiliated Practitioner List); C = claims run-out period; D = estimated completion date of QP determination

c. Partial QP Election to Report to MIPS

Eligible clinicians achieving Partial QP status may report to MIPS or may be excluded from MIPS; therefore, each individual Partial QP or group of Partial QPs must make a choice about MIPS participation and the choice must be communicated to CMS.¹⁹

CMS finalizes a policy requiring Advanced APM Entities to make a choice about MIPS reporting (or not) once the final determination has been made that the entity's clinicians are in fact QPs. The entity's choice applies to all eligible clinicians in the APM Entity group. Similarly, for circumstances wherein QP status is determined at an individual level (e.g., episode payment models with Affiliated Practitioner Lists), the individual clinician will choose MIPS reporting (or not) after being determined to be a QP. A choice not to report to MIPS, whether made by a group or an individual, will apply to all TINs associated with the group members' or individual's NPIs. For a Partial QP group, the APM Entity must opt in for the group to report to MIPS; the group will be excluded from MIPS if an explicit choice is not conveyed to CMS. In the absence of an explicit choice conveyed to CMS, an individual Partial QP who submits data to MIPS will be considered to have chosen to report to MIPS.

d. Notification of QP Determination

CMS will notify eligible clinician groups of their QP/Partial QP status determination results as soon as the determinations were made and the results were validated by CMS. . Consistent with the three-snapshot process and associated timeline, notifications will be made after each of the three QP determinations.

¹⁹ Sections 1848(q)(1)(C)(vii) and 1848(q)(1)(C)(ii)(II) of the Act, respectively

5. Qualifying APM Participant Determination: Medicare Option

a. Medicare Option: Attribution

In the final rule “attributed beneficiary” is defined as a beneficiary attributed to the Advanced APM Entity on the latest available list of attributed beneficiaries during the QP Performance Period based on each APM’s respective attribution rules. Beneficiary attribution rules vary across APMs, and this variation may create advantages for one APM versus another. Commonly used rules attribute beneficiaries based upon triggering defined episodes of care (e.g., CJR) or based upon where and from whom beneficiaries obtain the plurality of their evaluation and management services (e.g., CPC+). Under the rules of most APMs, beneficiaries cannot be attributed to more than one APM Entity. The latest available beneficiary lists to be used in this final rule vary slightly from those described in the proposed rule due to the sequential QP determinations process introduced in the final rule.

Attribution-eligible beneficiaries may or may not be attributed beneficiaries, while attributed beneficiaries are a subset of attribution-eligible beneficiaries. The attribution-eligible beneficiary concept limits the denominator of QP calculations to patients who could potentially be attributed to a given Advanced APM Entity and thus also appear in the numerator of the calculations. CMS finalizes basic eligibility criteria for attribution-eligible beneficiaries.²⁰

b. Medicare Option: Payment Amount Method

Per statute, CMS must use Part B covered professional services payments to make payment method QP determinations. In QP calculations, CMS will use all available Medicare Part B claims information generated during a QP performance period. CMS will also use a consistent approach to claims processing in calculating both Threshold Scores and APM Incentive Payment amounts. CMS also clarifies that payments for “incident to” covered professional services are included in threshold calculations while “incident to” payment Part B drugs, biologics, and devices are excluded.

The numerator would be the aggregate of all covered Part B professional services furnished by an Advanced APM Entity’s eligible clinicians to attributed beneficiaries during the QP Performance Period. The applicable range of service dates will vary depending on which of the three QP determinations during a performance period is being performed (see Figure F above).

The denominator will be the aggregate of all payments for Medicare Part B covered professional services furnished by an Advanced APM Entity’s eligible clinicians to attribution-eligible beneficiaries during the QP Performance Period. Further:

²⁰ The attribution-eligible beneficiary (1) is not enrolled in Medicare Advantage or a Medicare cost plan; (2) does not have Medicare as a secondary payer; (3) is enrolled in both Medicare Parts A and B; (4) is at least 18 years of age; (5) is a United States resident; and (6) has at least one evaluation and management service claim by an eligible clinician or group of eligible clinicians within an APM Entity for any period during the QP Performance Period.

- For QP determinations made at the eligible clinician level, the denominator would be the total of all Medicare Part B covered professional services payments for care furnished to attribution-eligible beneficiaries by the eligible clinician; and
- For QP determinations in episode payment models, payments included in the denominator would be those for Medicare Part B covered professional services provided to any attribution-eligible beneficiary by the Advanced APM Entity's eligible clinicians, whether or not the services occur during the course of an episode under the Advanced APM.

The applicable range of service dates will vary depending on which of the three QP determinations during a performance period is being performed (see Figure F above).

c. Medicare Option: Patient Count Method

CMS finalizes the following related to counting beneficiaries:

- A given beneficiary may be counted in both the numerator and denominator for multiple different Advanced APM Entities or eligible clinicians.
- A given beneficiary will not be counted more than once for any single Advanced APM Entity or eligible clinician; each unique beneficiary will be counted no more than one time in the numerator and one time in the denominator.
- Beneficiary counts will be based on any beneficiary for whom the eligible clinicians within an Advanced APM Entity receive payments for Part B covered professional services, even if an Advanced APM bases its attribution and/or financial risk on both Parts A and B.²¹
- Any and all available Part B claims information generated during the QP Performance Period will be included in the calculation.

The QP patient count threshold score numerator will be the number of unique attributed beneficiaries to whom eligible clinicians in the Advanced APM Entity furnish Medicare Part B covered professional services, or professional services at a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) during the QP determination timeframe. For episode payment models, the numerator will be the number of attributed beneficiaries furnished Medicare Part B covered professional services by eligible clinicians in the Advanced APM Entity during the course of an episode under the Advanced APM. CMS notes that the applicable range of service dates also will vary depending on which of the three QP determinations during a performance period is being performed (see Figure F above).

The QP patient count threshold score denominator will be the number of attribution-eligible beneficiaries to whom the Advanced APM Entity's eligible clinicians provide covered professional services during the timeframe used for QP determination. CMS notes that the applicable range of service dates will vary depending on which of the three QP determinations during a performance period is being performed (see Figure G above).

²¹ As discussed later in the final rule and in this summary, some services furnished at a Rural Health Clinic (RHC) or a Federally Qualified Health Center (FQHC) may also be counted.

Services Furnished Through CAHs, RHCs, and FQHCs

CMS will 1) include payments for Method II CAH professional services furnished by eligible clinicians in an Advanced APM Entity in the Threshold Score for the payment amount method, and 2) counting a beneficiary in the numerator of the Threshold Score for the patient count method if the beneficiary receives Method II CAH professional services furnished by eligible clinicians in an Advanced APM Entity or professional services furnished by eligible clinicians in an Advanced APM Entity at RHCs and FQHCs.

6. Combined All-Payer and Medicare Payment Threshold

a. Overview

Under section 1833(z)(2)(B)(ii) and (C)(ii) of the Act, there are two avenues for eligible clinicians to become QPs—the Medicare Option and the All-Payer Combination Option. An eligible clinician need only meet the threshold under one of them to be a QP for the payment year. If the thresholds are not met either as a QP (eligible for a 5 percent lump sum payment) or as a partial QP (no bonus, but not subject to MIPS), then these eligible clinicians would be subject to the requirements of the MIPS program. Under the Medicare Option, the payment amount threshold that an eligible clinician must meet to be a QP is at least 25% for 2019-2020, 50% for 2021-2022, and 75% for 2023 and beyond. Under the All-Payer Combination Option, clinicians can become QPs with lower levels of participation in Advanced APMs, through sufficient participation in Other Payer Advanced APMs with payers such as State Medicaid programs and commercial payers, including Medicare Advantage plans. The QP determination can be based on payment amount or on counts of patients in lieu of payments using the same or similar percentage criteria.

Table 36 in the final rule and reproduced below demonstrates the QP threshold amounts that must be met in a given year for a clinician to qualify as a QP under the All-Payer Combination Option using the payment amount method.

TABLE 36: QP Payment Amount Thresholds – All-Payer Combination Option

All-Payer Combination Option – Payment Amount Method										
Payment Year	2019	2020	2021		2022		2023		2024 and later	
QP Payment Amount Threshold	N/A	N/A	50%	25%	50%	25%	75%	25%	75%	25%
Partial QP Payment Amount Threshold	N/A	N/A	40%	20%	40%	20%	50%	20%	50%	20%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

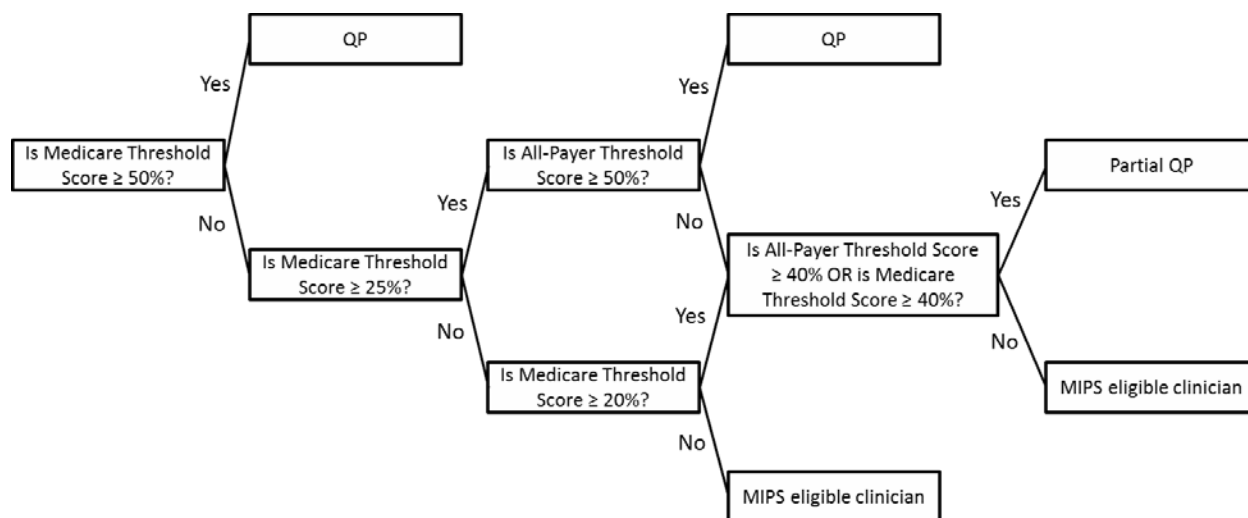
Table 37 in the final rule and reproduced below demonstrates the threshold amounts that must be met in a given year to qualify as a QP under the Patient Count Method.

TABLE 37: QP Patient Count Thresholds – All-Payer Combination Option

All-Payer Combination Option – Patient Count Method										
Payment Year	2019	2020	2021		2022		2023		2024 and later	
QP Patient Count Threshold	N/A	N/A	35%	20%	35%	20%	50%	20%	50%	20%
Partial QP Patient Count Threshold	N/A	N/A	25%	10%	25%	10%	35%	10%	35%	10%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

The QP determination process is shown in Figures H (2021-2022) and I (2023 and later). Figure H is reproduced below and shows the decision process which CMS will use to determine whether an eligible clinician would meet the payment amount threshold requirements.

FIGURE H: QP Determination Tree, Payment Years 2021-2022



In summary, CMS notes that eligible clinicians may become QPs if the following steps occur: (1) the eligible clinician submits to CMS sufficient information on all relevant payment arrangements with other payers; (2) CMS determines that at least one of those payment arrangements is an Other Payer Advanced APM; (3) the eligible clinician meets

the relevant QP thresholds by having sufficient payments or patients attributed to a combination of participation in Advanced APMs and Other Payer Advanced APMs.

b. Other Payer Advanced APM Criteria

(1) Overview

CMS notes, in general, a payment arrangement is an Other Payer Advanced APM if it meets three criteria:

- Certified Electronic Health Record technology (CEHRT) is used;
- Quality measures comparable to measures under the MIPS quality performance category apply; and
- The APM Entity either: (1) bears more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures; or (2) for beneficiaries under title XIX, is a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Act.

Payment arrangements under any payer other than traditional Medicare FFS, Medicare Advantage and other Medicare-funded private plans are categorized as a payer other than traditional Medicare for these purposes.

(2) Medicaid APMs

CMS finalizes its proposal to define a Medicaid APM as a payment arrangement under title XIX that otherwise meets the criteria to be an Other Payer Advanced APM. States can choose from different authorities in title XIX when implementing new payment models. CMS intends to generally defer to states in their design of payment arrangements.

(3) Medicaid Medical Home Model

CMS finalizes its proposal that a Medicaid Medical Home Model is a Medical Home Model that is operated under title XIX instead of under section 1115A of the Act. CMS notes that Medicaid Medical Home is not defined in title XIX or in Medicaid laws or in regulations. Analogous to its approach to Medical Home Models, CMS modifies and finalizes the two elements that all model participants must have:

- primary care focus (with participants that include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services) and involving specific design elements related to eligible clinicians with primary care specialty codes; CMS adds Obstetrics and Gynecology to the primary care specialty code list,²² and

²² The primary care specialty codes include 01 General Practice, 08 Family Medicine, 11 Internal Medicine, 16 Obstetrics and Gynecology, 37 Pediatric Medicine, 38 Geriatric Medicine, 50 Nurse Practitioner, 89 Clinical Nurse Specialist, and 97 Physician Assistant.

- empanelment of each patient to a primary clinician; CMS clarifies that patients may be empaneled to specialists as their primary clinicians.

CMS also finalizes that in addition to these required elements, Medicaid Medical Home Model must have at least four of the following seven elements:

- Planned chronic and preventive care.
- Patient access and continuity.
- Risk-stratified care management.
- Coordination of care across the medical neighborhood.
- Patient and caregiver engagement.
- Shared decision-making.
- Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings, population-based payments).

CMS notes that this definition of Medicaid Medical Home Model applies only for the purposes of the Quality Payment Program, and could be defined differently for other purposes. CMS does not mandate a specific method or accreditation process as it believes that doing so would provide limited additional benefit while unnecessarily restricting state innovation.

(4) Use of Certified Electronic Health Record Technology

Under section 1833(z)(2)(B)(iii)(II)(bb) and (z)(2)(C)(iii)(II)(bb) of the Act, to be an Other Payer Advanced APM, payments must be made under arrangements in which certified EHR technology is used. CMS states this is slightly different than the requirement for Advanced APMs that “requires participants in such model to use certified EHR technology (as defined in section 1848(o)(4) of the Act),” as specified in section 1833(z)(3)(D)(i)(I) of the Act. Although the statutory requirement is phrased slightly differently, CMS believes that there is value in keeping the two standards—for Advanced APMs and Other Payer Advanced APMs—as similar as possible.

Payment arrangements would meet this Other Payer Advanced APM criterion under sections 1833(z)(2)(B)(iii)(II)(bb) and (z)(2)(C)(iii)(II)(bb) of the Act by requiring participants to use CEHRT as defined for MIPS and APMs under §414.1305. CMS noted that this approach is consistent with the approach for Advanced APMs. CMS will adopt the same specifications from within the current definition of CEHRT in its regulation at §414.1305 for eligible clinicians participating in MIPS or in APMs.²³ This definition is identical to the definition for use by eligible hospitals and CAHs and Medicaid eligible clinicians in the EHR Incentive Programs.

Other Payer Advanced APMs must require at least 50 percent of eligible clinicians in each participating APM Entity (or each hospital if hospitals are the APM participants) to use the

²³ In the 2015 EHR Incentive Programs final rule (80 FR 62872 through 62873), CMS established the definition of CEHRT for EHR technology that must be used by eligible clinicians to meet the meaningful use objectives and measures in specific years.

certified health information technology functions outlined in the proposed definition of CEHRT to document and communicate clinical care with patients and other health care professionals.

(5) Application of Quality Measures Comparable to Those Under the MIPS Quality Performance Category

CMS finalizes its proposal that the quality measures on which the Other Payer Advanced APM bases payment must include at least one of the following types of measures, provided that they have an evidence-based focus and are reliable and valid:

- (1) Any of the quality measures included on the proposed annual list of MIPS quality measures;
- (2) Quality measures that are endorsed by a consensus-based entity;
- (3) Quality measures developed under section 1848(s) of the Act;
- (4) Quality measures submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act; or
- (5) Any other quality measures that CMS determines to have an evidence-based focus and are reliable and valid.

CMS also finalizes its proposal that an Other Payer Advanced APM must include at least one outcome measure if an appropriate measure (that is, the measure addresses the specific patient population and is specified for the APM participant setting) is available on the MIPS list of measures for that specific QP Performance Period. The outcome measure used does not have to be one of those on the MIPS quality measure list.

(6) Financial Risk for Monetary Losses

(a) Bearing Financial Risk for Monetary Losses

(i) Generally Applicable Other Payer Advanced APM Standard

CMS finalizes its proposal that the generally applicable financial risk standard for Other Payer Advanced APMs would be that a payment arrangement must, if the APM Entity's actual aggregate expenditures exceed expected aggregate expenditures during a specified performance period:

- (1) withhold payment for services to the APM Entity and/or the APM Entity's eligible clinicians;
- (2) reduce payment rates to the APM Entity and/or the APM Entity's eligible clinicians; or
- (3) require direct payments by the APM Entity to the payer.

(ii) Medicaid Medical Home Model Financial Risk Standard

The Medicaid Medical Home Model financial risk standard will apply for a Medicaid Medical Home Model if the APM Entity's actual aggregate expenditures exceed expected aggregate expenditures during a specified performance period. Under this payment arrangement standard, the Medicaid Medical Home Model must:

- Withhold payment for services to the APM Entity and/or the APM Entity's eligible clinicians;
- Reduce payment rates to the APM Entity and/or the APM Entity's eligible clinicians;

- Require direct payment by the APM Entity to the payer; or
- Require the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.

For example, a Medicaid Medical Home Model would meet the criterion if it conditions the payment of some or all of a regular care management fee to medical home APM Entities upon expenditure performance in relation to a benchmark. CMS believes this standard acknowledges the unique challenges of medical homes in bearing risk for losses while maintaining a more rigorous standard than mere business risk.

CMS finalizes its proposal that this limit will only apply to APM Entities that participate in Medicaid Medical Home Models and that have 50 or fewer eligible clinicians in the organization through which the APM Entity is owned and operated. This limitation will not apply to the first QP Performance Period that begins in 2017.

(b) Nominal Amount of Risk

CMS notes that when another payer risk arrangement meets the proposed financial risk standard, CMS would then consider whether the risk is of a more than nominal amount such that it meets this nominal risk standard. Similar to the CMS approach to the financial risk portion of the assessment, CMS' general approach is to adopt a generally applicable nominal amount standard for Other Payer Advanced APMs and a unique nominal amount standard for Medicaid Medical Home Models. This would include measuring three dimensions of risk to determine whether a model meets the nominal amount standard:

- (1) marginal risk refers to the percentage of the amount by which actual expenditures exceed expected expenditures for which an APM Entity would be liable under an payment arrangement—a common component of risk arrangements, particularly those that involve shared savings;
- (2) minimum loss rate (MLR), which is a percentage by which actual expenditures may exceed expected expenditures without triggering financial risk; and
- (3) total potential risk, which refers to the maximum potential payment for which an APM Entity could be liable under a payment arrangement.

(i) Generally Applicable Other Payer Advanced APM Nominal Amount Standard

To meet the Other Payer Advanced APM nominal amount standard, a payment arrangement's level of marginal risk must be at least 30 percent of losses in excess of the expected expenditures, and the maximum allowable MLR must be 4 percent.

Second, CMS finalizes that a payment arrangement must require APM Entities to bear financial risk for at least 3 percent of the expected expenditures for which an APM Entity is responsible under the payment arrangement (instead of the 4 percent proposed). For episode payment models, expected expenditures means the target price for an episode. CMS also indicates that it intends to establish through future rulemaking a total risk standard based on the revenue of the APM Entity from the payer in a manner that will parallel the standard it is finalizing in the Advanced APM nominal amount standard.

(ii) Medicaid Medical Home Model Nominal Amount Standard

For Medicaid Medical Home Models, CMS finalizes its proposal that the minimum total annual amount that an APM Entity must potentially owe or forego to be considered an Other Payer Advanced APM must be at least:

- In 2019, 4 percent of the APM Entity's total revenue under the payer.
- In 2020 and later, 5 percent of the APM Entity's total revenue under the payer.

(c) Capitation

CMS finalizes its proposal that full capitation risk arrangements will meet the same Other Payer Advanced APM financial risk criterion. A capitation risk arrangement, for purposes of this rulemaking, as a payment arrangement in which a per capita or otherwise predetermined payment is made to an APM Entity for services furnished to a population of beneficiaries, and no settlement is performed for the purpose of reconciling or sharing losses incurred or savings earned by the APM Entity. CMS reiterates that capitation should not simply be a cash flow mechanism and must be structured to directly hold the provider – or the entity to which the provider has assigned their billing – accountable.

Partial capitation arrangements can satisfy the financial risk criterion, but will not do so automatically and that they will be assessed according to the nominal amount standard. CMS finalizes its proposal without modification.

(d) Criteria Comparable to Expanded Medical Home Model

In accordance with sections 1833(z)(2)(B)(iii)(II)(cc)(BB) and (C)(iii)(II)(cc)(BB) of the Act, CMS finalizes its proposal that Medicaid Medical Home Models that meet criteria comparable to a Medical Home Model expanded under section 1115A(c) of the Act will meet the Other Payer Advanced APM financial risk criterion. CMS states it will specify in subsequent rulemaking the criteria of any Medical Home Model that is expanded under section 1115A(c) of the Act that will be used for purposes of making this comparability assessment. In the absence of any expanded Medical Home Model to which CMS could draw comparisons, Medicaid Medical Home Models must meet the financial risk criterion through the other provisions (the financial risk and nominal amount standards) in order to be an Other Payer Advanced APM.

(7) Medicare Advantage

CMS emphasizes that for the APM Incentive Payment, section 1833(z)(1)(A) of the Act states the APM Incentive Payment is based on payments for Part B covered professional services, which do not include payments for services furnished to MA enrollees. Under the All-Payer Combination Option for QP determinations, payment amounts or patient counts associated with Medicare Advantage plans can be counted, but do not count in the QP determination calculations under the Medicare Option.

CMS finalizes its proposal to evaluate payment arrangements between eligible clinicians, APMs Entities and MA plans according to the proposed Other Payer Advanced APM criteria. To qualify as an Other Payer Advanced APM, CMS notes that there must be a financial risk component. CMS will not consider an arrangement where the MA plan meets the CEHRT and quality measures criteria outlined but pays the APM Entity on a fee-for-service basis.

With respect to how MIPS adjustments and APM Incentive Payments will impact the benchmark rates used to determine monthly payments to MA plans, CMS states it will address its methodology for calculating CY 2019 MA benchmarks through the annual Advance Notice and Rate Announcement process.

c. Calculation of All-Payer Combination Option Threshold Score

(1) Use of Methods

CMS finalizes its proposal to calculate threshold scores for eligible clinicians in an Advanced APM Entity under both the payment amount and patient count methods for each QP Performance Period. CMS also finalizes its proposal that it will assign QP status using the more advantageous of the Advanced APM Entity's two scores. CMS states by using the greater of the Threshold Scores achieved, CMS hopes to promote simplicity in QP determinations and to maximize the number of eligible clinicians that attain QP status each year.

The policies for calculating Threshold Scores under the All-Payer Combination Option mirror those for the Medicare Option.

(2) Excluded Payments

As specified in the statute (Section 1833(z)(2)(B)(ii)(I) and (C)(ii)(I) of the Act), CMS will exclude certain payments from the calculation under the All-Payer Combination Option. CMS finalizes its proposal to exclude patients associated with these excluded payments from the patient count method. Specifically, the statute excludes payments made for the costs of Department of Defense (DoD) health care programs, costs of Department of Veterans Affairs health care programs, and Medicaid in states in which no Medicaid Medical Home Model or APM is available under the state plan.

CMS also finalizes its proposal that Medicaid payments or patients will be excluded in the numerator and denominator for the QP determination under both the payment amount and patient count methods unless:

- (1) a state has at least one Medicaid Medical Home Model or Medicaid APM in operation that is determined to be an Other Payer Advanced APM; and
- (2) the relevant Advanced APM Entity is eligible to participate in at least one of such Other Payer Advanced APMs during the QP Performance Period, regardless of whether the Advanced APM Entity actually participates in such Other Payer Advanced APMs.

(3) Payment Amount Method

CMS finalizes its proposal to calculate the All-Payer Combination Option Threshold Score for eligible clinicians in an Advanced APM Entity (or an eligible clinician that participates in multiple APMs) by dividing the numerator by the denominator as described below. The calculation is a ratio (numerator/denominator) converted into a percentage that results in a percent value threshold score.

CMS finalizes its proposal that the numerator is the aggregate of all payments from all other payers (except those excluded, such as DOD, VA, and certain Medicaid payments as described above) made to the Advanced APM Entity's eligible clinicians—or the eligible clinician in the event of an individual eligible clinician assessment—under the terms of all Other Payer Advanced APMs during the QP performance period. CMS notes that Medicare Part B covered professional services will be calculated under the All-Payer Combination Option in the same manner as it is for the Medicare Option.

CMS also finalizes its proposal that the denominator will be the aggregate of all payments from all payers, (except those excluded such as DOD, VA, and certain Medicaid payments) to the Advanced APM Entity's eligible clinicians—or the eligible clinician in the event of an individual eligible clinician assessment—during the QP Performance Period. CMS notes that the portion of this amount that relates to Medicare Part B covered professional services will be calculated under the All-Payer Combination Option in the same manner as it is for the Medicare Option.

CMS provides two examples in its Table 38 and Table 39 that illustrate how the calculations work. Table 38 is reproduced below from the final rule for illustration. In this CMS example, an Advanced APM Entity participates in a Medicare ACO initiative, a commercial ACO arrangement, and a Medicaid APM. Each of the APMs is determined to be an Advanced APM. In the QP Performance Period for payment year 2021 (2019), the Advanced APM Entity receives the following payments:

TABLE 38: All-Payer Combination Option Example 1

Payer	Payments through ACO	Total Payments from Applicable Payer	Threshold Score
Medicare*	\$300,000	\$1,000,000	30%
Commercial	\$300,000	\$500,000	60%
Medicaid	\$80,000	\$100,000	80%
Total	\$680,000	\$1,600,000	43%

*For Part B payments, the amount used for the All-Payer Combination Option will be the same as the amount tied to attribution-eligible beneficiaries used in the denominator of the calculation under the Medicare Option.

In the example, the Advanced APM Entity meets the minimum Medicare threshold (30% >25%). However, this entity does not meet QP Payment Amount Threshold (43% < 50%). In this case, the Advanced APM Entity would meet the Partial QP Payment Amount Threshold (43% >40%). In Table 39, CMS illustrates an example where eligible clinicians in the Advanced APM Entity would become QPs as the entity meets the minimum Medicare threshold and exceeds the QP Payment Amount Threshold.

(4) Patient Count Method

Analogous to the approach CMS finalizes under the payment amount method, CMS finalizes a patient count method to determine whether eligible clinicians meet the established QP threshold amounts in a given year to qualify as a QP under the All-Payer Combination Option. CMS notes that it will determine the QP status of an eligible clinician for the year based on the higher of the two values. The calculation is a ratio (numerator/denominator) converted into a percentage that results in a percent value threshold score.

CMS finalizes its proposal that like the Medicare Option, the patient count method under the All-Payer Combination Option will only count unique patients, with multiple eligible clinicians able to count the same patient. Similarly, CMS finalizes its proposal to count a single patient, where appropriate, in the numerator and denominator for multiple different Advanced APM Entities. CMS also finalizes its proposal that CMS will not count any patient more than once for any single Advanced APM Entity. CMS states that counting patients in this way maintains integrity by preventing double counting of patients within an Advanced APM Entity while recognizing the reality that patients often have relationships with eligible clinicians in different organizations.

CMS finalizes its proposal that the numerator will be the number of unique patients to whom eligible clinicians in the Advanced APM Entity furnish services that are included in the measures of aggregate expenditures used under the terms of all of their Other Payer Advanced APMs (non-Medicare portion) during the QP Performance Period, plus the patient count numerator for Advanced APMs (Medicare portion). A patient would count in the non-Medicare portion of this numerator only if, as stated above, the eligible clinician furnishes services to the patient and receives payment(s) for furnishing those services under the terms of an Other Payer Advanced APM.

CMS finalizes its proposal that the denominator will be the number of unique patients to whom eligible clinicians in the Advanced APM Entity furnish services during the QP Performance Period (except those excluded such as DOD, VA, and certain Medicaid patients).

CMS provides two examples of patient count threshold score calculations in Tables 40 and 41 in the final rule. Table 41 is reproduced below to illustrate how CMS performs the calculation. In this example, the Advanced APM Entity meets the minimum Medicare threshold (40% > 20%). It also exceeds the minimum QP Patient Count Threshold (61% > 35%). In this case, the eligible clinicians in the Advanced APM Entity would become QPs.

TABLE 41: All-Payer Combination Option Example 4

Payer	Patients through ACO	Total Patients from Payer	Threshold Score
Medicare*	2,000	5,000	40%
Commercial	4,000	5,000	80%
Medicaid	1,000	1,500	67%
Total	7,000	11,500	61%

*For Medicare Part B patients, the amount used for the All-Payer Combination Option will be the same as the number of attribution-eligible beneficiaries used in the denominator of the calculation under the Medicare Option.

d. Submission of Information for Assessment under the All-Payer Combination Threshold Option

CMS finalizes its proposal that to be considered under the All-Payer Combination Option, APM Entities or individual eligible clinicians must submit by a date and in a manner determined by CMS:

- (1) Payment arrangement information necessary to assess whether each payment arrangement is an Other Payer Advanced APM, including information on financial risk arrangements, use of certified EHR technology, and payment tied to quality measures; and
- (2) For each payment arrangement, the amounts of revenues for services furnished through the arrangement, the total revenues from the payer, the numbers of patients furnished any service through the arrangement (that is, patients for whom the eligible clinician is at risk if actual expenditures exceed projected expenditures), and the total number of patients furnished any service through the payer.

CMS will then make the determination and notify the APM Entities and/or eligible clinicians of the Other Payer Advanced APM determinations based on their submissions. CMS finalizes its proposal that an Other Payer Advanced APM is required to have an outcome measure, or attest that there is no applicable outcome measure on the MIPs list. CMS notes its intent to establish specific requirements regarding the timing and manner of submission of such information through future rulemaking.

With respect to timing, CMS finalizes its proposal to make an early Other Payer Advanced APM determination on other payer arrangements if sufficient information is submitted at least 60 days before the beginning of a QP Performance Period. To the extent permissible by federal law, CMS also finalizes its proposal to maintain confidentiality of certain information (such as sensitive contractual information or trade secrets) provided by Advanced APM Entities and/or eligible clinicians. Unlike its proposal for Advanced APM determinations, the Other Payer Advanced APM determinations will be made available directly to participating APM Entities and eligible clinicians rather than through public notice. CMS goes on to say that it will explain how and within what timeframes such notifications will occur in subregulatory guidance. CMS may consider publicly releasing on the CMS website general and/or aggregate information on the payers involved and the scope of such agreements.

CMS notes that information submitted as part of this determination is subject to audit and that eligible clinicians and Advanced APM Entities will be required to maintain copies of any supporting documentation. To the extent an audit reveals a material discrepancy, the APM Incentive Payment may be recouped. CMS notes it will provide further details on the audit and recoupment process under the All-Payer Combination Option in future rulemaking.

7. APM Incentive Payment

a. Amount of the APM Incentive Payment

CMS will make an APM Incentive Payment to eligible clinicians that achieve QP status for the year during years 2019 through 2024. In accordance with the statute, CMS finalizes its proposal that this APM Incentive Payment shall be equal to 5 percent of the estimated aggregate amounts paid for Medicare Part B covered professional services furnished by the eligible clinician from the preceding year across all billing TINs associated with the QP's NPI.

(1) Timeframe of Claims

CMS finalizes its proposal to calculate the APM Incentive Payment based on data available 3 months after the end of the incentive payment base period in order to allow time for claims to be processed. For example, for the 2019 payment year, CMS will capture claims submitted with dates of service from January 1, 2018 through December 31, 2018 and processing dates of January 1, 2018 through March 31, 2019.

Based on the timeframe of claims, CMS estimates that incentive payments could be made approximately 6 months after the end of the incentive payment base period, or roughly mid-way through the payment year. CMS finalizes its proposal that the APM Incentive Payment will be made no later than one year from the end of the incentive payment base period.

(2) Treatment of Payment Adjustments in Calculating the APM Incentive Payment

CMS finalizes its proposal to exclude the MIPS, VM, MU and PQRS payment adjustments when calculating the estimated aggregate payment amount for covered professional services upon which to base the APM Incentive Payment amount.

(3) Treatment of Payments for Services Paid on a Basis Other than Fee-For-Service

CMS recognizes that many APMs use incentives and financial arrangements that differ from usual fee schedule payments. The statute requires CMS to establish policies for when payment is made on a basis other than fee-for-service. CMS places such payments into three categories: financial risk payments, supplemental service payments, and cash flow mechanisms.

Financial Risk Payments

CMS defines financial risk payments as non-claims-based payments, based on performance in an APM when an APM Entity assumes responsibility for the cost of a beneficiary's care, whether it be for an entire performance year, or for a shorter duration of time, such as over the course of a defined episode of care. CMS notes that in the context of categorizing these types of payments as "financial risk payments," CMS refers to payments that may be based on the cost of a beneficiary's care and does not necessarily limit these payments to financial arrangements that would require an APM Entity to accept downside risk. CMS will consider shared savings payments to ACOs in all tracks of the MSSP to be financial risk payments as well as net payment reconciliation amounts from CMS to an Awardee (or vice versa) under the BPCI Initiative, and reconciliation payments or repayment amounts under the CJR model to be examples of financial risk payments.

CMS will exclude financial risk payments such as shared savings payments or net reconciliation payments, when calculating the estimated aggregate payment amount.

Supplemental Service Payments

CMS defines supplemental service payments as Medicare Part B payments for longitudinal management of a beneficiary's health, or for services that are within the scope of medical and other health services under Medicare Part B that are not separately reimbursed through the physician fee schedule. CMS cites per-beneficiary per-month (PBPM) payments that are made for care management services as an example.

CMS finalizes its proposal to determine on a case-by-case basis whether certain supplemental service payments are in lieu of covered services that are reimbursed under the PFS. In cases where payments are for covered services that are in lieu of services reimbursed under the PFS, those payments will be considered covered professional services and will be included in the APM Incentive Payment amounts. Specifically, CMS finalizes its proposal to include a supplemental service payment in calculation of the APM Incentive Payment amount if it meets all of the following 4 criteria:

1. Payment is for services that constitute physician services authorized under section 1832(a) of the Act and defined under section 1861(s) of the Act.
2. Payment is made for only Part B services under the first criterion above, that is, payment is not for a mix of Part A and Part B services.

3. Payment is directly attributable to services furnished to an individual beneficiary.
4. Payment is directly attributable to an eligible clinician.

CMS finalizes its proposal to establish a process by which it notifies the public of the supplemental service payments in all APMs and identify the supplemental service payments that meet its proposed criteria and will be included in the APM Incentive Payment calculations. This list will be posted on the CMS website.

Cash Flow Mechanisms

CMS defines cash flow mechanisms as changes in the method of payments for services furnished by providers and suppliers participating in an APM Entity. CMS cites the population-based payment (PBP) available in the Pioneer ACO Model and the Next Generation ACO Model as examples of a cash flow mechanism. PBP provides ACOs with a monthly lump sum payment in exchange for a percentage reduction in Medicare fee-for-service payments to certain ACO providers and suppliers.

For expenditures affected by cash flow mechanisms, CMS finalizes its proposal to calculate the estimated aggregate payment amount using the payment amounts that would have occurred for Part B covered professional services if the cash flow mechanism had not been in place. For example, for QPs in an ACO receiving PBP with a 50 percent reduction in fee-for-service payments, CMS will use the amount that would have been paid for Part B covered professional services in the absence of the 50 percent reduction.

Payments made to an APM Entity Instead of An Eligible Clinician

Section 1833(z)(1)(A)(i) of the Act requires CMS to establish policies for payments that are made to an Advanced APM Entity rather than directly to a QP. For instance, in the recently announced CPC+ Model, the supplemental service payments (that is, the care management fees) meet all of its proposed criteria to be included in the APM Incentive Payment calculations. The care management fees are only for Medicare Part B covered professional services, but these payments for attributed beneficiaries are aggregate payments made to each CPC+ Practice Site. To allocate payments made to an APM entity rather than an eligible clinician, CMS finalizes its proposal that it will divide such payments equally across all eligible clinicians who are on the Participation List for that APM Entity, and each eligible clinician who is a QP will be considered to have been paid that portion of the payments for purposes of the APM Incentive Payment amount calculations.

(4) Treatment of Other Incentive Payments in Calculating the Amount of APM Incentive Payments

CMS, by statute, will not include the HPSA Physician Bonus Program, Primary Care Incentive Payment (PCIP) program, and the HPSA Surgical Incentive Payment (HSIP), when calculating the APM Incentive Payment.

(5) Treatment of the APM Incentive Payment in APM Calculations

CMS notes the statutory language in Section 1833(z)(1)(C) that states the amount of the APM Incentive Payment shall not be taken into account for purposes of determining actual expenditures under an APM and for purposes of determining or rebasing any benchmarks used under the APM. CMS anticipates that each APM will have in place a procedure to avoid counting APM Incentive Payments toward determining actual expenditures or rebasing any benchmarks under the APM.

b. Services Furnished Through CAHs, RHCs, and FQHCs

(1) Critical Access Hospitals (CAHs)

CMS indicates that professional services furnished at a Method II CAH are considered “covered professional services” because they are furnished by an eligible clinician and payment is based on the Medicare Physician Fee Schedule. Therefore, the APM Incentive Payment would be based on the amounts paid for those services attributed to the eligible clinician, as identified using the attending NPI included on a submitted claim, in the same manner as all other covered professional services. For an eligible clinician who becomes a QP based on covered professional services furnished at a Method II CAH, CMS finalizes its proposal that the APM Incentive Payment will be made to the CAH TIN that is affiliated with the Advanced APM Entity.

(2) Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS states payment for services furnished by eligible clinicians in RHCs and FQHCs is not reimbursed under or based on the PFS. Therefore, professional services furnished in those settings would not be considered part of the amount upon which the APM Incentive Payment is based. For eligible clinicians that practice in RHCs or FQHCs, this does not preclude the inclusion of payment amounts for covered professional services furnished by those eligible clinicians in other settings. This only excludes payments made for RHC and FQHC services furnished by the eligible clinicians. CMS finalizes its proposal that professional services furnished in RHCs and FQHCs will not constitute covered professional services under section 1848(k)(3)(A) of the Act and will not be considered part of the amount upon which the APM Incentive Payment is based.

c. Payment of the APM Incentive Payment

(1) Payment to the QP

CMS finalizes its proposal that for eligible clinicians that are QPs, CMS will make the APM Incentive Payment to the TIN that is affiliated with the Advanced APM Entity through which the eligible clinician met the threshold during the QP performance period.

CMS states that it recognizes that there may be scenarios in which an individual eligible clinician may change his or her affiliation between the QP Performance Period and the payment year such that the eligible clinician no longer practices at the TIN affiliated with the Advanced APM Entity. In this instance, CMS finalizes its proposal to make the APM Incentive Payment to the TIN provided on the eligible clinician's CMS-588 EFT Application. CMS notes that this approach is consistent with how it has made incentive payments under other programs.

(2) Exception for Eligible Clinicians in Multiple Advanced APMs

For purposes of making the QP determination at the individual eligible clinician level, CMS finalizes its proposal to split the APM Incentive Payment amount proportionally across all of the QP's TINs associated with Advanced APM Entities. For example, if an eligible clinician is a QP who participates in two APMs (APM 1 and APM 2), and has 75 percent of his or her payments (or patients) used to make the QP determination through APM 1 and 25 percent of his or her payments (or patients) used to make the QP determination through APM 2, CMS will make 75 percent of the APM Incentive Payment to the TIN affiliated with APM 1, and 25 percent of the APM Incentive Payment to the TIN affiliated with APM 2. CMS believes this approach is most consistent with the statute and encourages participation in APMs.

(3) Notification of APM Incentive Payment Amount

CMS anticipates that notification of the APM Incentive Payment amount will likely not occur at the same time as the notification of QP status; CMS anticipates that notification will occur later in the year to allow for accurate calculation and validation of the incentive payment amount. CMS will send notification to both Advanced APM Entities and their individual participating QPs of their APM Incentive Payment amount as soon as CMS has calculated and performed the necessary validation of results.

In addition, CMS finalizes its proposal that the APM Incentive Payment amount notification will be made directly to QPs along with a general public notice that such calculations have been completed for the year. For the direct QP notification, CMS intends to include the amount of APM Incentive Payment and the TIN to which the incentive payments will be made. If the incentive payment is split across multiple TINs, CMS intends to identify which TINs CMS will make the incentive payment to, and include the amount of APM Incentive Payment that will be made to each TIN. For the notification to Advanced APM Entities, CMS intends to include the total amount of APM Incentive Payments that will be made to each participating TIN within the Advanced APM Entity, as well as QP specific payment amounts.

8. Monitoring and Program Integrity

CMS finalizes its proposal to monitor Advanced APM Entities and eligible clinicians on an ongoing basis for non-compliance with the conditions of participation for Medicare and the terms of the relevant Advanced APMs in which they participate during the QP Performance Period. CMS states that this will include vetting of applicants to Advanced APMs and their compliance with the conditions of participation of Medicare and ongoing, periodic assessments of Advanced APM Entities and eligible clinicians by APMs in conjunction with the CMS

Center for Program Integrity and other relevant federal government departments and agencies.

CMS finalizes its proposal that if an Advanced APM Entity or eligible clinician is terminated from the program during the QP Performance Period for program integrity reasons, or if the Advanced APM Entity or eligible clinician is out of compliance with program requirements, CMS may reduce or deny the APM Incentive Payment to such eligible clinicians. In addition, CMS states that if an eligible clinician is later terminated due to a program integrity matter arising during the QP Performance Period, CMS may recoup all or a portion of the amount of the payment from the entity to which CMS made the payment. Furthermore, CMS finalizes its proposal that CMS will reopen and recoup any payments that were made in error in accordance with procedures similar to those set forth at §§405.980 and 405.370 et seq. or established under the relevant APM.

CMS also finalizes its proposal that Advanced APM Entities and eligible clinicians must maintain copies of all records related to the All-Payer Combination Option for at least ten years and must provide the government with access to these records for auditing and inspection purposes. If an audit reveals that the information submitted is inaccurate, CMS may recoup the APM Incentive Payment. CMS also notes that nothing in this proposed rule limits or restricts the authority of the Office of the Inspector General.