2017

CY 2018 Updates to the Quality Payment Program (QPP) and QPP Extreme and Uncontrollable Circumstance Policy for the Transition Year

A SIDE-BY-SIDE COMPARSION OF KEY PROVISIONS FROM THE PROPOSED AND FINAL RULES IMPLEMENTING YEAR TWO OF THE QPP.

HHS | Hart Health Strategies Inc.

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Overview

On November 2, 2017, the Centers for Medicare and Medicaid Services (CMS) released its long-awaited CY 2018 Updates to the Quality Payment Program (QPP); and QPP Extreme and Uncontrollable Circumstance Policy for the Transition Year. The QPP was established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Under the QPP, eligible clinicians can participate via one of two tracks: Advanced Alternative Payment Models (APMs); or the Merit-based Incentive Payment System (MIPS). CMS began implementing the QPP through rulemaking for calendar year (CY) 2017. This final rule with comment period provides updates for the second and future years of the QPP.

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

The provisions of this final rule with comment period and interim final rule with comment period are effective on January 1, 2018. Comments must be received no later than 5 p.m. on **January 1, 2018**.

An executive summary of this rule is available here.

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MIPS Eligible Clinicians		
Definition of a MIPS Eligible Clinician	CMS does not propose any changes to its previously established definition of a MIPS eligible clinician. Here, CMS provides additional clarifications on which specific Part B services are subject to the MIPS payment adjustment, as well as which Part B services are included for eligibility determinations. When Part B items or services are furnished by suppliers that are also MIPS eligible clinicians, there may be circumstances in which it is not operationally feasible for CMS to attribute those items or services to a MIPS eligible clinician at an NPI level in order to include them for purposes of applying the MIPS payment adjustment or making eligibility determinations. For example, in the case of a MIPS eligible clinician who furnishes a Part B covered item or service, such as prescribing Part B drugs that are dispensed, administered, and billed by a supplier that is a MIPS eligible clinician, or ordering DME that is administered and billed by a supplier that is a MIPS eligible clinician, it is not operationally feasible for CMS at this time to associate those billed allowed charges with a MIPS eligible clinician at an NPI level in order to include them for purposes of applying the MIPS payment adjustment or making eligibility determinations. However, for those billed Medicare Part B allowed charges that CMS is able to associate with a MIPS eligible clinician at an NPI level, such items and services would be included for purposes of applying the MIPS payment adjustment or making eligibility determinations.	CMS made no changes to this section.
Group Practice	CMS reiterates its group practice definition established under the 2017 QPP final rule, clarifying that it considers a group to be either an entire single TIN or portion of a TIN that: (1) is participating in MIPS according to the generally applicable scoring criteria while the remaining portion of the TIN is participating in a MIPS APM or an Advanced APM according to the MIPS APM scoring standard; and (2) chooses to participate in MIPS at the group level. Group size determinations are based on the number of NPIs associated with a TIN, which would include eligible clinicians who may be excluded from MIPS participation and do not meet the definition of a MIPS eligible clinician.	CMS made no changes to this section, but clarifies that except for groups containing APM participants, it is not permitting groups to "split" TINs if they choose to participate in MIPS as a group.

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Small Practices	In the CY 2017 QPP final rule, CMS defined the term small practices at §414.1305 as "practices consisting of 15 or fewer clinicians and solo practitioners." CMS proposes to make eligibility determinations regarding the size of small practices for performance periods occurring in 2018 and future years. This is to account for small practice size in advance of a performance period for operational purposes relating to assessing and scoring the improvement activities performance category, determining hardship exceptions for small practices, calculating the small practice bonus for the final score, and identifying small practices eligible for technical assistance. Again, the size of a group practice would be determined before exclusions are applied. The claim-based determination period would include a 12-month assessment period, which consists of an analysis of claims data that spans from the last 4 months of a calendar year 2 years prior to the performance period followed by the first 8 months of the next year and includes a 30-day claims run out (e.g., September 1, 2016 to August 31, 2017 for the 2018 performance period). This would allow CMS to inform small practices of their status near the beginning of the performance period. To better reflect the real-time size of practices, CMS considered two alternative determination periods/processes: 1. Expand the period to 24 months with two 12-month segments of data analysis (before and during the performance period); or 2. Include an attestation component, in which a small practice that was not identified as a small practice during the proposed small practice size determination period would be able to attest to the size of their group practice prior to the performance period.	To resolve inconsistency and ensure greater consistency with established MIPS terminology, ***CMS is modifying this definition of a small practice to mean a "practice consisting of 15 or fewer eligible clinicians."*** This modification is not intended to substantively change the definition of a small practice (p. 54). ***CMS finalized its decision to make small practice size determinations prior to the performance period. It will utilize a 12-month assessment period, which consists of an analysis of claims data that spans from the last 4 months of a calendar year 2 years prior to the performance period followed by the first 8 months of the next calendar year and includes a 30-day claims run out for the small practice size determination***. Thus, it anticipates providing MIPS eligible clinicians with their small practice size determination by Spring 2018 for the 2018 performance period. CMS believes this is the most straightforward approach that will provide notify small practices of their status near the beginning of the performance period so that practices can plan accordingly (p. 54).
Rural Area and Health Professional Shortage Area Practices	CMS proposes the definition of rural areas at §414.1305 as ZIP codes designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data set. For performance periods occurring in 2018 and future years, CMS believes that a higher threshold than one practice within a TIN is necessary to designate an individual eligible clinician, group, or virtual group as a rural or HPSA practice. Similar to the 75% threshold adopted in 2017 for determining whether a group is non-patient facing, CMS proposes that an individual MIPS eligible clinician, a group, or a virtual	***CMS finalized these policies as proposed*** (p. 55).

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	group would be designated as a rural or HPSA practice if more than 75% of NPIs billing under the individual MIPS eligible clinician or group's TIN or within a virtual group, as applicable, are designated in a ZIP code as a rural area or HPSA.	
Non-Patient Facing MIPS Eligible Clinicians	In order to account for the formation of virtual groups starting in 2018, CMS proposes to modify the definition of a non-patient facing MIPS eligible clinician to mean 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 or virtual group provided that more than 75% of the NPIs billing under the group's TIN or within a virtual group, as applicable, meet the definition of a non-patient facing individual MIPS eligible clinician during the determination period. For performance year 2018 and beyond, CMS would use E&M codes and Surgical and Procedural codes for accurate identification of patient-facing encounters, and thus, accurate eligibility determinations regarding non-patient facing status. A patient-facing encounter is considered to be an instance in which the individual MIPS eligible clinician or group billed for items and services furnished such as general office visits, outpatient visits, and procedure codes under the PFS. For performance periods occurring in 2018 and future years, CMS proposes a modification to the non-patient facing determination period, in which the initial 12-month segment of the non-patient facing determination period would span from the last 4 months of a calendar year 2 years prior to the performance period followed by the first 8 months of the next calendar year and include a 30-day claims run out; and the second 12-month segment of the non-patient facing determination period would span from the last 4 months of a calendar year 1 year prior to the performance period followed by the first 8 months of the performance period in the next calendar year and include a 30-day claims run out. This proposal would only change the duration of the claims run out, not the 12-month timeframes used for the first and second segments of data analysis. CMS would maintain its policy of not changing 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.	***CMS finalized these policies as proposed*** (p. 69).

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	CMS also would maintain its policy that MIPS eligible clinicians who are considered to be non-patient facing, including groups with more than 75% of NPIs billing under the TIN meeting the definition of non-patient facing, will have their ACI performance category automatically reweighted to zero.	
MIPS Eligible Clinicians Who Practice in Critical Access Hospitals Billing under Method II (Method II CAHs)	As established in the 2017 final rule, the MIPS payment adjustment will apply to Method II CAH payments under section 1834(g)(2)(B) of the Act when MIPS eligible clinicians who practice in Method II CAHs have assigned their billing rights to the CAH.	No changes to this policy.
MIPS Eligible Clinicians Who Practice in Rural Health Clinics (RHCs) or Federally Qualified Health Centers (FQHCs)	As established in 2017, services rendered by an eligible clinician under the RHC or FQHC methodology, will not be subject to the MIPS payments adjustments.	No changes to this policy.
MIPS Eligible Clinicians Who Practice in Ambulatory Surgical Centers (ASCs), Home Health Agencies (HHAs); Hospice, and Hospital Outpatient Departments (HOPDs)	CMS clarifies and proposes to formalize its policy that if a MIPS eligible clinician furnishes items and services in an ASC, HHA, Hospice, and/or HOPD and the facility bills for those items and services (including prescription drugs) under the facility's all-inclusive payment methodology or prospective payment system methodology, the MIPS adjustment would not apply to the facility payment itself. However, if a MIPS eligible clinician furnishes other items and services in an ASC, HHA, Hospice, and/or HOPD and bills for those items and services separately, such as under the PFS, the MIPS adjustment would apply to payments made for such items and services. Such items and services would also be considered for purposes of applying the low-volume threshold.	***CMS finalized this policy as proposed*** (p. 72).
MIPS Eligible Clinician Identifier	CMS clarifies its intent to continue to use Individual, Group, and APM Entity Group Identifiers for performance, noting that the same identifier must be used for all four performance categories. CMS also will continue to use a single identifier, TIN/NPI, for applying the MIPS payment adjustment, regardless of how the MIPS eligible clinician is assessed.	No changes to this policy.
Exclusions		
New Medicare-Enrolled Eligible Clinician	CMS proposes no changes to this definition or the status of this current exclusion. Determinations are made based on the CY of the applicable performance period, during which CMS conducts eligibility determinations on a quarterly basis, as feasible.	No changes to this policy.

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Qualifying APM Participant (QP) and Partial Qualifying APM Participant (Partial QP)	CMS proposes no changes to this definition or the status of this current exclusion.	No changes to this policy.
Low-Volume Threshold	To reduce burden and mitigate confounding variables impacting performance under MIPS, CMS proposes to modify this threshold, starting with the 2018 performance year, to exclude individual eligible clinicians or groups that have Medicare Part B allowed charges less than or equal to $90,000 OR that provide care for 200 or fewer Part B-enrolled Medicare beneficiaries. Low-volume threshold determinations would be made at the individual and group level, and not at the virtual group level. The low-volume threshold also applies to MIPS eligible clinicians who practice in APMs under the APM scoring standard at the APM Entity level, in which APM Entities do not exceed the low-volume threshold. In such cases, the eligible clinicians participating in the MIPS APM Entity would be excluded from the MIPS requirements for the applicable performance period and not subject to a MIPS payment adjustment for the applicable year. Such an exclusion would not affect an APM Entity's QP determination if the APM Entity is an Advanced APM. CMS proposes to maintain the 12-month timeframes used for the first and second segment of data analysis, but to include a 30-day claims run out (vs. a 60-day claims run out) for the low-volume threshold determination period. For purposes of the 2021 MIPS payment year (2019 performance), CMS also proposes to provide clinicians the ability to opt-in to the MIPS if they meet or exceed one, but not all, of the low-volume threshold determinations.	***CMS finalized the bulk of these changes in policy as proposed*** (p. 94). CMS believes that raising the threshold for the 2018 performance year will give these excluded clinicians, particularly those in smaller practices and rural areas, additional time to further invest in the necessary infrastructure to prepare for their potential participation in MIPS future years without subjecting them to a potential negative payment adjustment. According to its updated data models, the revised low-volume threshold will exclude approximately 123,000 additional clinicians from MIPS from the approximately 744,000 clinicians that would have been eligible based 2017 criteria. ***CMS did not finalize its proposal to provide an opt-in for low-volume clinicians for the 2019 performance* period** (p. 93). CMS is concerned it won't be able to operationalize this policy in a low-burden manner to clinicians. However, it plans to revisit this policy in the next rulemaking cycle. Overall, CMS' goal is to implement a process whereby a clinician can be made aware of their low-volume threshold status and make an informed decision on whether they will participate in MIPS or not. As such, CMS seeks comment on: • ***Ways to implement the low-volume threshold opt-in that does not add additional burden to clinicians;*** • ***Ways to mitigate the concern that only high-performers will choose to opt-in; and*** • ***Whether its current application of the low-volume threshold to groups is still appropriate.***
Group Reporting		
General	CMS reiterates previously finalized group reporting policies in this section.	As noted above, CMS finalized its decision to use claims data to make small practice size determinations.

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	As noted earlier, CMS proposes to modify this policy by using claims data to make small practice size determinations. CMS also would modify group reporting policies to account for clinicians seeking to form or join a virtual group.	
Virtual Groups		
General	For 2018, CMS proposes 3 ways to participate in MIPS: (1) Individual-level reporting; (2) Group-level reporting; and (3) Virtual group-level reporting.	No changes to this policy.
Definition of a Virtual Group	In accordance with 1848(q)(5)(I) of the Act, CMS proposes to define a virtual group as a combination of two or more TINs *composed of* a solo practitioner (a MIPS eligible clinician who bills under a TIN with no other NPIs billing under such TIN), or a group with 10 or fewer eligible clinicians under the TIN that elects to form a virtual group with at least one other such solo practitioner or group for a performance period for a year. Groups must include at least one MIPS eligible clinician in order to meet the definition of a group and thus be eligible to form or join a virtual group. In order for a solo practitioner to be eligible to form or join a virtual group, the solo practitioner would need to be considered a MIPS eligible clinician who bills under a TIN with no other NPIs billing under such TIN, and not excluded from MIPS as a result of being newly enrolled in Medicare; a QP; a Partial QP who chooses not to report on measures and activities under MIPS; or an eligible clinician who does not exceed the low-volume threshold. In order for a group to be eligible to form or join a virtual group, a group would need to have a TIN size that does not exceed 10 eligible clinicians and is not excluded from MIPS based on the low-volume threshold exclusion at the group level.	***CMS finalized with modification its proposal to define a solo practitioner at §414.1305 as a practice consisting of one eligible clinician (who is also a MIPS eligible clinician). CMS also finalized with modifications its proposal to define a virtual group at §414.1305 as a combination of two or more TINs assigned to one or more solo practitioners or one or more groups consisting of 10 or fewer eligible clinicians, or both, that elect to form a virtual group for a performance period for a year***. These changes are simply intended to provide greater clarity and consistency with established MIPS terminology (p. 112).
	For groups (TINs) that participate in MIPS as part of a virtual group and do not contain participants in a MIPS APM or an Advanced APM, each MIPS eligible clinician under the TIN (each TIN/NPI) will receive a MIPS payment adjustment based on the virtual group's combined performance assessment (combination of TINs). For groups (TINs) that participate in MIPS as part of a virtual group and contain participants in a MIPS APM or an Advanced APM, only the portion of the TIN that is being scored for MIPS according to the generally applicable scoring criteria will receive a	***CMS finalized this policy as proposed*** (p. 112).

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	MIPS adjustment based on the virtual group's combined performance assessment (combination of TINs). The remaining portion of the TIN that is being scored according to the APM scoring standard will receive a MIPS payment adjustment based on that standard. Such participants may be excluded from MIPS if they achieve QP or Partial QP status. To maintain flexibility, CMS does not propose to establish any required classifications regarding virtual group composition nor any limits on the number of TINs that may form a virtual group limit at this time. In response to public feedback, CMS intends to explore the feasibility of establishing an option that would permit a portion of a group to participate in MIPS outside the group by reporting as a separate subgroup (outside of the virtual group option). CMS would create such functionality through a new identifier. CMS solicits public comment on this potential strategy.	In future rulemaking, CMS intends to explore the feasibility of establishing group-related policies that would permit participation in MIPS at a subgroup level and create such functionality through a new identifier. CMS will take comments on subgroup level policies that it has received to date into consideration for future rulemaking. ***CMS seeks comment on additional ways to define a group, not solely based on a TIN. For example, redefining a group to allow for practice sites to be reflected and/or for specialties within a TIN to create groups*** (p. 98).
MIPS Virtual Group Identifier for Performance	CMS proposes that each MIPS eligible clinician who is part of a virtual group would be identified by a unique virtual group participant identifier, which will be a combination of three identifiers: (1) virtual group identifier (established by CMS; for example, XXXXXX); (2) TIN (9 numeric characters; for example, XXXXXXXXX); and (3) NPI (10 numeric characters; for example, 1111111111). For example, a virtual group participant identifier could be VG- XXXXXX, TINXXXXXXXXX, NPI- 11111111111.	***CMS finalized this policy as proposed*** (p. 115). To clarify, a virtual group is recognized as an official collective entity for reporting purposes, but is not a distinct legal entity for billing purposes. As a result, a virtual group does not need to establish a new TIN for purposes of participation in MIPS, nor does any eligible clinician in the virtual group need to reassign their billing rights to a new or different TIN. CMS intends to notify virtual groups of their official status as close to the start of the performance period as technically feasible since virtual groups will need to provide their virtual group identifiers to the third party intermediaries that will be submitting their performance data.
Application of MIPS Group Policies to Virtual Groups	CMS proposes to apply its previously finalized and newly proposed group policies to virtual groups. • Application of *non-patient facing policies* to virtual groups: CMS proposes to modify the definition of a non-patient facing MIPS eligible clinician to include clinicians in a virtual group provided that more than 75% of the NPIs billing under the virtual group's	***CMS finalized these policies as proposed*** (p. 127). In response to public comments, CMS also clarified that a virtual group will be considered a certified or recognized patient-centered medical home or comparable specialty practice if at least 50% of the practices sites within the TINs are certified or recognized as a patient-centered

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	TINs meet the definition of a non-patient facing individual. Other policies previously established and proposed in this proposed rule for non-patient facing groups also would apply to virtual groups (e.g., virtual groups determined to be non-patient facing would have their ACI performance category automatically reweighted to zero). • Application of *small practice status* to virtual groups: For performance periods occurring in 2018 and future years, a virtual group with 75% or more of the TIN's practice sites designated as rural areas or HPSA practices would be designated as a rural area or HPSA at the group level. Other policies previously established and proposed in this proposed rule for rural area and HPSA groups would also apply to virtual groups. • *Measures and activities*: Virtual groups would be required to meet the reporting requirements for each measure and activity, and the virtual group would be responsible for ensuring that their measures and activities are aggregated across the virtual group (i.e., across their TINs).	medical home or comparable specialty practice. In this case, the virtual group would receive full credit in the improvement activities performance category (p. 128). It also clarified that, in regards to the improvement activities performance category requirements, groups and virtual groups would receive credit for an improvement activity as long as one NPI under the group's TIN or virtual group's TINs performs an improvement activity for a continuous 90-day period (p. 126). Finally, CMS clarified that for purposes of the advancing care information (ACI) category, the policies pertaining to groups will apply to virtual groups. Performance on the ACI objectives and measures will be reported and evaluated at the virtual group level. The virtual group will submit the data that its TINs have utilizing CEHRT and exclude data collected from a non-certified EHR system (i.e., only those data contained in CEHRT should be reported for the ACI category). The virtual group calculation of the numerators and denominators for each measure must reflect all of the data from the individual MIPS eligible clinicians (unless a clinician can be excluded) that have been captured in CEHRT for the given measure. If the groups (not including solo practitioners) that are part of a virtual group have CEHRT that is capable of supporting group level reporting, the virtual group would submit the aggregated data across the TINs produced by the CEHRT. If a group (TIN) that is part of a virtual group does not have CEHRT that is capable of supporting group level reporting, such group would 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 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. Also, when aggregating performance on ACI measures for virtual group level reporting, CMS does not require that a virtual group determines that a patient seen by one MIPS eligible clinician (or at one location in the case of TINs working with multiple CEHRT systems) is not also seen by another MIPS eligible clinician in the TIN that is part of the virtual group or captured in a different CEHRT system (p. 124).

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Virtual Group Election Process	As required by statute, CMS proposes that a solo practitioner or a group of 10 or fewer eligible clinicians must make their virtual group election prior to the start of the applicable performance period and cannot change their election during the performance period. For the 2018 and 2019 performance periods, CMS propose a two-stage virtual group election process, stage 1 of which is optional. Those electing to be in a virtual group must do so by December 1 of the calendar year preceding the applicable performance period. Groups would be able to inquire about virtual group participation eligibility as early as September of each year prior to the applicable performance period. For purposes of determining TIN size for virtual group participation eligibility, CMS will adopt a "virtual group eligibility determination period" during which it will analyze claims data during an assessment period of up to five months that would begin on July 1 and end as late as November 30 of the calendar year prior to the performance year and include a 30-day claims run out. If at any time a TIN is determined to be eligible to participate in MIPS as part of a virtual group, the TIN would retain that status for the duration of the applicable performance period. Starting in September prior to the applicable performance year beginning in 2018, groups would be able to inquire about virtual group participation eligibility as part of stage 1 of the election process. CMS recognizes that the size of a TIN may fluctuate during a performance period with eligible clinicians and/or MIPS eligible clinicians joining or leaving a group. For groups within a virtual group that are determined to have a group size of 10 eligible clinicians or less, any new eligible clinicians or MIPS eligible clinicians that join the group during the performance period would participate in MIPS as part of the virtual group. Also, in the case of a TIN within a virtual group being acquired or merged with another TIN, or no longer operating as a TIN (e.g., a group practice closes) during a performance period, such solo practitioner or group's performance data would continue to be attributed to the virtual group. The remaining members of a virtual group would continue to be part of the virtual group even if only one solo practitioner or group remains. Also per the statute, virtual group participants may elect to be in no more than one virtual group for a performance period and, in the case of a group, the election applies to all MIPS eligible clinicians in the group.	***CMS finalized these policies as proposed. However, it finalized a modified election period deadline. Beginning with performance periods occurring in 2018, virtual group elections must occur by December 31 of the calendar year preceding the applicable performance period*** (p. 138). For QPP Year 3, CMS intends to provide an electronic election process, if technically feasible.
Virtual Group	CMS proposes that each virtual group member would be required to	***CMS finalized with modification this proposal at §414.1315(c)(3)***

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Agreements	execute formal written agreements with each other virtual group member to ensure that requirements and expectations of participation in MIPS are clearly articulated, understood, and agreed upon.	***regarding virtual group agreements.*** CMS will require a formal written agreement between each solo practitioner and group that composes a virtual group; the revised regulation text makes it clear the formal written virtual group agreement must identify, but need not include as parties to the agreement, all eligible clinicians who bill under the TINs that are components of the virtual group. For greater clarity, the formal written agreement must include the following elements: • Identifies the parties to the agreement by name of party, TIN, and NPI, and includes as parties to the agreement only the groups and solo practitioners that compose the virtual group; • Is executed on behalf of each party by an individual who is authorized to bind the party; • Expressly requires each member of the virtual group (and each NPI under each TIN in the virtual group) to participate in MIPS as a virtual group and comply with the requirements of the MIPS and all other applicable laws and regulations (including, but not limited to, federal criminal law, False Claims Act, anti-kickback statute, civil monetary penalties law, the HIPAA, and physician self-referral law); • Identifies each NPI under each TIN in the virtual group and requires each TIN within a virtual group to notify all NPIs associated with the TIN of their participation in the MIPS as a virtual group; • Sets forth the NPI's rights and obligations in, and representation by, the virtual group, including without limitation, the reporting requirements and how participation in MIPS as a virtual group affects the ability of the NPI to participate in the MIPS outside of the virtual group; • Describes how the opportunity to receive payment adjustments will encourage each member of the virtual group (and each NPI under each TIN in the virtual group) to adhere to quality assurance and improvement; • Requires each party to the agreement to update its Medicare enrollment information, including the addition and deletion of NPIs billing through its TIN, on a timely basis in accordance with Medicare program requirements and to notify the virtual group of any such changes within 30 days after the change; • Is for a term of at least one performance period as specified in the formal written agreement;

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		• Requires completion of a close-out process upon termination or expiration of the agreement that requires each party to the virtual group agreement to furnish, in accordance with applicable privacy and security laws, all data necessary in order for the virtual group to aggregate its data across the virtual group (p. 154)
Virtual Group Reporting Requirements	CMS believes virtual groups should generally be treated under MIPS as groups. CMS proposed the following requirements: • Individual eligible clinicians and individual MIPS eligible clinicians who are part of a TIN participating in MIPS at the virtual group level would have their performance assessed as a virtual group; • Eligible clinicians and individual MIPS eligible clinicians who are part of a TIN participating in MIPS at the virtual group level would need to meet the definition of a virtual group at all times during the performance period for the MIPS payment year; • Individual eligible clinicians and individual MIPS eligible clinicians who are part of a TIN participating in MIPS at the virtual group level must aggregate their performance data across multiple TINs in order for their performance to be assessed as a virtual group; • MIPS eligible clinicians that elect to participate in MIPS at the virtual group level would have their performance assessed at the virtual group level across all four MIPS performance categories; • Virtual groups would need to adhere to an election process established and required by CMS.	***CMS finalized these policies as proposed*** (p. 172). CMS clarified here that virtual groups are able to utilize the same multiple submission mechanisms that are available to groups. For the 2018 performance period, groups and virtual groups can utilize multiple submission mechanisms, but only use one submission mechanism per performance category. Starting with the 2019 performance period, groups and virtual groups will be able to utilize multiple submission mechanisms for each performance category. CMS clarified here that groups and virtual groups are required to submit one QRDA III file for each performance category. Given that virtual groups are required to aggregate their data at the virtual level and submit one file of data per performance category, there may be circumstances that would require a virtual group to combine their files in order to meet the submission requirements. Concerns were raised about placing the responsibility of data aggregation on the virtual group, which could be burdensome and a barrier for small and rural practices. CMS responded that it is not technically feasible for the agency to perform this task at this juncture, but that they will consider it in the future. Concerns were also raised about the legal and operational complexity of data sharing, aggregation and submission among disparate TINs, and how certain specialty registries may have internal governance standards complicating how they would support virtual groups. Similarly, concerns were raised about challenges pertaining to the use of disparate EHR systems across the virtual group. ***To support implementation of the virtual group option, CMS intends to issue subregulatory guidance pertaining to data aggregation for virtual groups, including the responsibilities of third party vendors.*** Concerns were raised that reporting performance data for all NPIs under a TIN participating in a virtual group, particularly non-MIPS eligible clinicians who are excluded from MIPS participation, would be a

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		regulatory burden to virtual groups. However, CMS believes that it would be more burdensome for virtual groups to determine which clinicians are MIPS eligible versus not MIPS eligible and remove performance data for non-MIPS eligible clinicians when reporting as a virtual group. While entire TINs participate in a virtual group, including each NPI under a TIN, and are assessed and scored collectively as a virtual group, CMS clarifies that only NPIs that meet the definition of a MIPS eligible clinician would be subject to a MIPS payment adjustment. CMS also clarified here the manner in which the data completeness thresholds would apply to virtual groups. Since it applies cumulatively across all TINs in a virtual group, there may be a case when a virtual group has one TIN that falls below the 60% data completeness threshold, which is an acceptable case as long as the virtual group cumulatively exceeds such threshold. CMS also clarified here that if each MIPS eligible clinician within a virtual group faces a significant hardship or has EHR technology that has been decertified, the virtual group can apply for an exception to have its ACI performance category reweighted. In response to request that CMS hold virtual groups harmless from penalties during the initial years of implementation, CMS clarified that it is not authorized to do that under statute. ***Finally, CMS notes that is has developed a web-based portal submission system that streamlines and simplifies the submission of data at the individual, group, and virtual group level, including the utilization of multiple submission mechanisms (one submission mechanism per performance category), for each performance category***. CMS will issue guidance at https://qpp.cms.gov/ pertaining to the utilization and functionality of such portal.

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Virtual Group Assessment and Scoring	Virtual groups would be assessed and scored across all four MIPS performance categories at the virtual group level for a performance period of a year. CMS would assign the virtual group score, based on the virtual group's aggregated performance, to all TIN/NPIs billing under a TIN in the virtual group during the performance period. However, the payment adjustment would still be applied at the TIN/NPI level. If there are NPIs in a TIN that have joined a virtual group that are also participants in an APM, the TIN must submit performance data for all eligible clinicians associated with the TIN, including those participating in APMs, to ensure that all eligible clinicians associated with the TIN are being measured under MIPS. MIPS eligible clinicians who are participants in both a virtual group and a MIPS APM would be assessed under MIPS as part of the virtual group and under the APM scoring standard as part of an APM Entity group, but would receive their payment adjustment based only on the APM Entity score instead of the score of their virtual group. In the case of an eligible clinician participating in both a virtual group and an Advanced APM who has achieved QP status, the clinician would be assessed under MIPS as part of the virtual group, but would still be excluded from the MIPS payment adjustment as a result of his or her QP status.	***CMS finalized these policies as proposed*** (p. 184). CMS further clarified here that affirmatively agreeing to participate in MIPS as part of a virtual group prior to the start of the applicable performance period would constitute an explicit election to report under MIPS. Thus, eligible clinicians who participate in a virtual group and achieve Partial QP status would remain subject to the MIPS payment adjustment due to their election to report under MIPS. Also, new Medicare-enrolled eligible clinicians and clinician types not included in the definition of a MIPS eligible clinician who are associated with a TIN that is part of a virtual group would receive a virtual group score, but would not receive a MIPS payment adjustment. CMS also noted here that virtual groups are generally able to take advantage and benefit from all scoring incentives and bonuses that are currently provided under MIPS. CMS also acknowledged requests to address risk adjustment and other methodologies to account for the unique and potentially heterogeneous make-up of virtual groups. CMS is continuing to analyze this issue and will incorporate findings as feasible and appropriate through future rulemaking.
MIPS Performance Period		
General	*2020 MIPS payment year.* CMS previously finalized that for the quality and cost categories, the performance period would be the full calendar year (CY) 2018 (January 1, 2018 through December 31, 2018). For the improvement activities and advancing care information performance categories, the performance period would be a minimum of a continuous 90-day period within CY 2018 and up to and including the full CY 2018. *2021 MIPS payment years*. For the quality and cost performance categories, the performance period under MIPS would be CY 2019 for the 2021 payment year. For the improvement activities and advancing care information performance categories, the performance period would be a minimum of a continuous 90-day period within the calendar year that occurs two years prior to the applicable payment year, up to and including the full calendar year.	***2020 MIPS payment year.*** **No changes were made to this policy.** ***2021 MIPS payment year.*** **CMS finalized this policy as proposed.** ***CMS is not finalizing a performance period for future years so that it can continue to monitor and assess whether changes to the performance period through future rulemaking would be beneficial*** (p. 193). Despite ongoing operational challenges that are not expected to be resolved in the near future, CMS continues to look for ways to shorten the timeframe between the end of the performance period and when payment adjustments are applied.

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		In response to concerns about the timing of the release of measures specifications in light of the calendar year performance period, CMS clarified that it would post approved QCDR measures through the qualified posting by no later than January 1, 2018. In response to concerns about the inconsistent requirements across performance categories, CMS felt the flexibilities being offered outweigh any complexity.
MIPS Performance Category Measures and Activities		
Submission Mechanisms	Beginning with 2018, CMS proposes to allow individual MIPS eligible clinicians and groups to submit data on measures and activities, as applicable, via multiple data submission mechanisms for a single performance category. Individual MIPS eligible clinicians and groups that have fewer than the required number of measures and activities applicable and available under one submission mechanism could be required to submit data on additional measures and activities via one or more additional submission mechanisms, as necessary, provided that such measures and activities are applicable and available to them in order to receive the maximum number of points under a performance category. Virtual groups also would be able to use a different submission mechanism for each performance category, and would be able to utilize multiple submission mechanisms for the quality performance category, beginning with performance periods occurring in 2018. However, virtual groups would be required to utilize the same submission mechanism for the improvement activities and the advancing care information performance categories.	***Due to public concerns and operational issues, CMS did not finalize this policy for the 2018 performance year.*** ***However, CMS did finalize this proposal, with modification, beginning with the 2019 performance period.*** For purposes of the 2021 MIPS payment year and future years, individual MIPS eligible clinicians, groups, and virtual groups may submit data on measures and activities, as applicable, via multiple data submission mechanisms for a single performance category. Individual MIPS eligible clinicians and groups that have fewer than the required number of measures and activities applicable and available under one submission mechanism may submit data on additional measures and activities via one or more additional submission mechanisms, as necessary, provided that such measures and activities are applicable and available to them (p. 214). CMS clarified here that it is not requiring that MIPS individual clinicians and groups submit via additional submission mechanisms; however, through this proposal the option would be available for those that have applicable measures and/or activities available to them. As discussed later in this rule, CMS will apply its validation process to determine if other measures are available and applicable only with respect to the data submission mechanism(s) that a MIPS eligible clinician utilizes for the quality performance category for a performance period. With regard to a specialty measure set, specialists who report on a specialty measure set are only required to report on the measures within that set, even if it is less than the required 6 measures. If the specialty set

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		includes measures that are available through multiple submission mechanisms, then through this policy, beginning with the 2019 performance period, the option to report additional measures would be available for those that have applicable measures and/or activities available to them, which may potentially increase their score, but they are not required to utilize multiple submission methods to meet the 6 measure requirement. In addition, for MIPS eligible clinicians reporting on a specialty measure set via claims or registry, CMS will apply its validation process to determine if other measures are available and applicable within the specialty measure set only with respect to the data submission mechanism(s) that a MIPS eligible clinician utilizes for the quality performance category for a performance period. CMS also clarifies here that for performance periods beginning in 2019, if a MIPS eligible clinician or group reports for the quality performance category by using multiple instances of the same data submission mechanism (e.g., multiple QCDRs) then all the submissions would be scored, and the 6 quality measures with the highest performance (i.e., the greatest number of measure achievement points) would be utilized for the quality performance category score. If individual MIPS eligible clinician or group submits the same measure through two different mechanisms, each submission would be calculated and scored separately. CMS does not have the ability to aggregate data on the same measure across multiple submission mechanisms.
Submission Deadlines	CMS does not propose any changes to its previously finalized policies: The data submission deadline for the qualified registry, QCDR, EHR, and attestation submission mechanisms is March 31 following the close of the performance period (i.e., March 31, 2019 for the 2018 performance period). Data submitted on claims with dates of service during the performance period must be processed no later than 60 days following the close of the performance period. For the CMS Web Interface submission mechanism, CMS specified that the data must be submitted during an 8-week period following the close of the performance period that will begin no earlier than January 2, and end no later than March 31.	CMS maintains these policies.
Quality Performance Criteria	*Contribution to Final Score.* Using its authority to assign different weights during the first two years of MIPS, CMS proposes that for the 2020 MIPS payment year, the quality performance category will account for 60% of the final score to account for its decision to once again reweight the cost performance category to 0%.	***After consideration of public comments, CMS did not finalize this proposal and will be keeping its previously finalized policy (81 FR 77100), to weight the quality performance category at 50% for the 2020 MIPS payment year*** (p. 223). This decision is a result of CMS not finalizing its proposal to reweight the cost performance category to 0% for MIPS payment year 2020. CMS believes that by keeping its current policy to

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	As previously finalized, for the 2021 payment year and future years of MIPS, CMS intends to weigh the quality category at 30% of the MIPS final score.	weight the quality performance period at 50% and the cost performance category at 10%, it will help ease the transition so that MIPS eligible clinicians can understand how they will be scored in future years under MIPS generally and the cost performance category in particular. CMS also reiterates here that the cost performance category and the quality category will be weighted at 30% beginning with MIPS payment year 2021, as required by statute. In response to recommendations that the Improvement Activity (IA) category be weighted more heavily, particularly for non-patient facing clinicians who lack relevant quality measures, CMS clarified that it cannot weight the IA category more heavily because section 1848(q)(5)(E)(i)(III) of the Act specifies that the improvement activities performance category will account for 15% of the final score. In response to concerns that in some cases, the only applicable measures are worth less points, CMS noted that non-patient facing MIPS eligible clinicians may report on a specialty-specific measure set (which may have fewer than the required six measures) or may report through a QCDR that can report QCDR measures in order to earn the full points in the quality performance category.
	Quality Data Submission Criteria. Except with regard to the CAHPS for MIPS survey, CMS does not propose any changes to the submission criteria or definitions established for measures in the 2017 final rule. CMS also does not propose any changes to the submission criteria for quality measures for groups reporting via the CMS Web Interface.	CMS maintains these policies. CMS revised §414.1335(a)(2) simply to clarify that the CMS Web Interface criteria applies only to groups of 25 or more eligible clinicians (p. 229).
	For groups electing to report the CAHPS for MIPS Survey, CMS proposes for 2018 and future years that the survey administration period would, at a minimum, span over 8 weeks to a maximum of 17 weeks and would end no later than February 28th following the applicable performance period. CMS also proposes, for 2018 and future years, to remove two Summary Survey Measures (SSMs) from the CAHPS for MIPS survey; specifically, "Helping You to Take Medication as Directed," due to low reliability, and "Between Visit Communication."	***CMS finalized these CAHPS for MIPS Survey requirements as proposed*** (p. 237).
	CMS also seeks comment on expanding, through future rulemaking, the patient experience data publically available for the CAHPS for MIPS survey to include five open-ended questions. These questions have been developed and tested in order to capture patient narratives in a	Comments received on these two issues are summarized starting on p. 233.

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	scientifically grounded and rigorous way, setting them apart from other patient narratives collected by various health systems and patient rating sites. User testing has shown that users regularly request more information from patients like them in their own words. CMS also seeks comments on ways to assign and sample patients using data from other payers.	
	Data Completeness Criteria. CMS proposes for payment year 2020 to maintain the current data completeness thresholds for the quality category: • Registry: 50% of all applicable patients, regardless of payer; • QCDR: 50% of all applicable patients, regardless of payer; • EHR: 50% of all applicable patients, regardless of payer; • Claims: 50% of all applicable Medicare Part B patients For the 2021 payment year, CMS proposes the following data completeness thresholds for the quality category: • Registry: 60% of all applicable patients, regardless of payer; • QCDR: 60% of all applicable patients, regardless of payer; • EHR: 60% of all applicable patients, regardless of payer; • Claims: 60% of all applicable Medicare Part B patients CMS notes its intent to steadily increase these thresholds over time through future rulemaking and seeks comment on what data completeness threshold should be established for future years.	***For the 2018 performance period (2020 payment year), CMS did not finalize its proposal regarding the data completeness criteria for MIPS payment year 2020. Instead, it will retain its previously finalized data completeness threshold of:*** • ***Registry: 60% of all applicable patients, regardless of payer;*** • ***QCDR: 60% of all applicable patients, regardless of payer;*** • ***EHR: 60% of all applicable patients, regardless of payer;*** • ***Claims: 60% of all applicable Medicare Part B patients*** For the 2021 payment year (2019 performance period), CMS did finalize its proposal regarding the data completeness criteria: • ***Registry: 60% of all applicable patients, regardless of payer;*** • ***QCDR: 60% of all applicable patients, regardless of payer;*** • ***EHR: 60% of all applicable patients, regardless of payer;*** • ***Claims: 60% of all applicable Medicare Part B patients*** (p. 244) Table 5 reflects CMS' ***final quality data submission criteria for MIPS payment years 2020 and 2021*** via Medicare Part B claims, QCDR, qualified registry, EHR, CMS Web Interface, and the CAHPS for MIPS survey. In this section, CMS recognizes the need for gradual implementation, but also cites the importance of incorporating higher thresholds to ensure a more accurate assessment of a MIPS eligible clinician's performance on the quality measures and to avoid any selection bias. CMS also acknowledged, but did not respond to, a suggestion that for any reporting mechanism for which a MIPS eligible clinician could attest to a formal, auditable representative sampling, CMS should exempt the MIPS eligible clinician from the data completeness standard. CMS also clarifies here that the measure reporting requirements applicable to groups are also generally applicable to virtual groups. However, these requirements apply cumulatively across all TINs in a

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		virtual group. Thus, virtual groups will aggregate data for each NPI under each TIN within the virtual group by adding together the numerators and denominators and then cumulatively collate to report one measure ratio at the virtual group level. As a result, there may be situations where a virtual group has one TIN that falls below the 60% data completeness threshold, which is an acceptable case as long as the virtual group cumulatively exceeds such threshold. In regard to the CMS Web Interface and CAHPS for MIPS survey, sampling requirements pertain to Medicare Part B patients with respect to all TINs in a virtual group, where the sampling methodology would be conducted for each TIN within the virtual group and then cumulatively aggregated across the virtual group. A virtual group would need to meet the beneficiary sampling threshold cumulatively as a virtual group.
	Application of Quality Measures to Non-Patient Facing MIPS Eligible Clinicians. CMS does not propose any changes to the policy that non-patient facing MIPS eligible clinicians would be required to meet the applicable submission criteria that apply for all MIPS eligible clinicians for the quality performance category.	CMS maintains this policy (p. 247).
	Global and Population-Based Measures. CMS does not propose any changes to the use of the all-cause hospital readmissions (ACR) measure. It would continue to apply to groups of 16 or more who meet the case volume of 200 cases. A group will be scored on the ACR measure even if it did not submit any quality measures, if it submitted in other performance categories. Otherwise, the group will not be scored on the readmission measure if it did not submit data in any of the performance categories (i.e., a MIPS payment adjustment would not be based on this measure alone).	CMS maintains these policies (p. 248).
	Selection of MIPS Quality Measures for Individual MIPS Eligible Clinicians and Groups Under the Annual List of Quality Measures Available for MIPS Assessment. Table A includes proposed new MIPS quality measures for inclusion in MIPS for the 2018 performance period and future years. Table B includes proposed new and modified MIPS specialty sets for the 2018 performance period and future years. Some of the specialty sets have further defined subspecialty sets, each of which is effectively a separate specialty set. In instances where an individual MIPS eligible clinician or group reports on a specialty or subspecialty set, if the set has less than six measures, that is all the clinician is required to report. The specialty measure sets continue to serve as a guide and are not required. Table C.1 includes specific MIPS quality measures proposed for removal	***Quality measures finalized in this rule are listed in the rule's appendix:*** • ***Table A: new quality measures available for reporting in MIPS for the 2018 performance period and future years;*** • ***Table B: finalized specialty measure sets available for reporting in MIPS for the 2018 performance period and future years;*** • ***Table C.1: MIPS quality measures removed only from specialty sets for the 2018 performance period and future years;*** • ***Table C.2: MIPS quality measures removed from the MIPS program for the 2018 performance period and future years;*** • ***Table D: cross-cutting measures available for the 2018 MIPS performance period and future years (note: there is no cross-cutting measure reporting requirement);*** • ***Table E: MIPS quality measures finalized with substantive***

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	only from specialty sets for 2018. CMS proposes to remove cross-cutting measures from most of the specialty sets. Table C.2 includes specific MIPS quality measures proposed for removal from MIPS for 2018. Table D includes proposed cross-cutting measures. CMS continues to consider cross-cutting measures to be an important part of its quality measure programs. Although not required at this point in time, it seeks comment on ways to incorporate cross-cutting measures into MIPS in the future. Table E includes MIPS quality measures with proposed substantive changes. Tables 14, Table 15, and Table 16 include measures that would be used to calculate a quality score for the APM scoring standard. CMS also seeks comments on whether there are any MIPS quality measures that should be classified in a different NQS domain than what is being proposed, or that should be classified as a different measure type (e.g., process vs. outcome) than what is being proposed in this rule.	***changes for the 2018 performance period and future year.*** Additional discussion about the selection of MIPS quality measures starts on p. 205. CMS reiterates in this section that it will apply the following considerations when considering quality measures for possible inclusion in MIPS: • Measures that are not duplicative of an existing or proposed measure; • Measures that are beyond the measure concept phase of development and have started testing, at a minimum, with strong encouragement and preference for measures that have completed or are near completion of reliability and validity testing; • Measures that include a data submission method beyond claims-based data submission; • Measures that are outcome-based rather than clinical process measures (CMS will likely reject non-outcome measures unless (1) there is substantial documented and peer reviewed evidence that the clinical process measured varies directly with the outcome of interest; and (2) it is not possible to measure the outcome of interest in a reasonable timeframe. • Measures that address patient safety and adverse events; • Measures that identify appropriate use of diagnosis and therapeutics; • Measures that address the domain for care coordination; • Measures that address the domain for patient and caregiver experience; • Measures that address efficiency, cost, and resource use; • Measures that address significant variation in performance; • CMS is also likely to reject measures that do not provide substantial evidence variation in performance. CMS also clarifies here that MIPS eligible clinicians are not required to report on the specialty or sub-specialty measure sets—they are simply intended to serve as a guide for clinicians to choose measures applicable to their specialty. In instances where an individual MIPS eligible clinician or group reports on a specialty or subspecialty set, if the set has less than six measures, that is all the clinician is required to report.
	Topped Out Measures. CMS proposes a 3-year timeline for identifying	***CMS finalized these policies as proposed, stating its belief that topped***

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	and proposing to remove topped out measures. After a measure has been identified as topped out for three consecutive years, CMS may propose to remove the measure through comment and rulemaking for the 4th year. Thus, in the 4th year, if finalized through rulemaking, the measure would be removed and would no longer be available for reporting during the performance period. CMS proposes to phase in this policy starting with a select set of six highly topped out measures identified in the scoring section of the rule. It also proposed to phase in special scoring for measures identified as topped out in the published benchmarks for 2 consecutive performance periods, starting with the select set of highly topped out measures for the 2018 MIPS performance period. For all other measures, the timeline would apply starting with the benchmarks for the 2018 MIPS performance period. Thus, the first year any other topped out measure could be proposed for removal would be in rulemaking for the 2021 MIPS performance period, based on the benchmarks being topped out in the 2018, 2019, and 2020 MIPS performance periods. CMS does not propose to include CMS Web Interface measures in its proposal to remove topped out measures since CMS Web Interface align with the Shared Savings Program and because reporters would not have the ability to select other measures if measures were removed.	***out measures may provide little room for improvement for the majority of MIPS eligible clinicians and may disproportionately impact the scores for certain MIPS eligible clinicians*** (p. 268). As such, the earliest the select set of six highly topped out measures could be proposed for removal would be in rulemaking for the 2020 MIPS performance period. The earliest all other measures could be proposed for removal due to topped out status would be in rulemaking for the 2021 MIPS performance period. CMS clarified here that QCDR measures that consistently are identified as topped out according to the same timeline would not be approved for use in year 4 during the QCDR self-nomination review process. Removal of these QCDR measures would not go through the comment and rulemaking process as MIPS quality measures would. CMS disagreed with commenters that the removal of QCDR measures should occur through the notice-and-comment rulemaking process, as QCDR measures are not approved for use in the program through rulemaking and Sec. 1848(q)(2)(D)(vi) of the Act expressly provides that QCDR measures are not subject to the notice-and-comment rulemaking requirements described in section 1848(q)(2)(D)(i) of the Act that apply to other MIPS measures. CMS intends to indicate which measures are topped out through the benchmarks that will be published on the QPP website annually, as feasible prior to the beginning of each performance period. CMS clarified that if the measure benchmark is not topped out during one of the 3 MIPS performance periods, then the lifecycle would stop and start again at year 1 the next time the measure benchmark is topped out. Also, if for some reason a measure benchmark is topped out for only one submission mechanism benchmark, then CMS would remove that measure from the submission mechanism, but not remove the measure from other submission mechanisms available for submitting that measure. CMS recognizes that there are certain types of high value measures such as patient safety and patient experience, but it disagrees that such measures should be designated as never to be removed from the list of available quality measures. Nevertheless, in response to concerns about this policy, CMS noted that as part of the topped out measure timeline, it

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		will take into consideration other factors such as clinical relevance and the availability of other relevant specialty measures prior to deciding whether or not to remove a measure from the program. Each removal would need to be proposed and finalized through rulemaking, and CMS would have the discretion to retain any particular measure that, after consideration of public comments and other factors, may be determined to be inappropriate for removal.
	Non-Outcome Measures. CMS does not propose to remove non-outcome measures in this proposed rule, but seeks additional comment on what the best timeline for removing both non-outcome and outcome measures that cannot be reliably scored against a benchmark for 3 years in a row.	CMS maintains these policies (p. 269).
	Quality Measures Determined to be Outcome Measures. CMS does not make any proposals on how quality measures are determined to be outcome measures, but outlines the criteria utilized in determining if a measure is considered an outcome measure and seeks comments on these criteria.	CMS maintains these policies and will take comments received into consideration for future rulemaking (p. 269).
Performance Category	In this rule, CMS proposes to change the weight of the cost performance category from 10% to 0% for the 2020 MIPS payment year. This additional year would help to increase understanding of the measures so that clinicians are more comfortable with their role in reducing costs for their patients, and allow for the development and refinement of episode-based cost measures. However, CMS also seeks comment on keeping the weight of the cost performance category at 10% for the 2020 MIPS payment year.	***For the 2020 MIPS payment year, CMS did not finalize its proposal to weight the cost category at 0%, and instead adopted its alternative option to maintain the 10% weight for the cost performance category in order to ease the transition to a 30% weight for the cost performance category in the 2021 MIPS payment year*** (p. 279). CMS felt that assigning a 0% weight to the cost performance category for the 2020 MIPS payment year may not provide a smooth enough transition for integrating cost measures into MIPS and may not provide enough encouragement to clinicians to review their performance on cost measures. In response to recommendations that CMS weight the cost performance category at 10% in the 2020 MIPS payment year only for those clinicians who volunteer to be measured on cost, CMS noted that it does not have the statutory authority to score cost measures on a voluntary basis under MIPS. In response to requests that CMS use flexibility in the statute to weight the cost performance category at 0% (or a percentage lower than 30%) for the third MIPS payment year, CMS stated that it does not believe the statute affords it the flexibility to adjust this prescribed weight, unless CMS determines there are not sufficient cost measures applicable and available to MIPS eligible clinicians under section 1848(q)(5)(F) of the Act.

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		CMS also clarified that although it is committed to ensuring flexibilities for small practices, it does not have the statutory authority to exempt small practices from the cost performance category. CMS recognized that not every clinician will have cost measures attributed to them in the initial years of MIPS and therefore may not receive a cost performance category score. However, it does not believe that it is appropriate to exclude certain clinicians from cost measurement on the basis of their specialty if they are attributed a sufficient number of cases to meet the case minimum for the cost measure. As described in the scoring section of this rule, a MIPS eligible clinician must be attributed a sufficient number of cases for at least one cost measure, and that cost measure must have a benchmark, in order for the clinician to receive a cost performance category score.
	Total Per Capita Cost and MSPB Measures. For the 2018 MIPS performance period and future performance periods, CMS proposes to include in the cost performance category the Total Per Capita Cost measure and the MSPB measure as finalized for the 2017 MIPS performance period. The Total Per Capita cost measure is a global measure of all Medicare Part A and Part B costs during the performance period. It has been used in the Value Modifier program since the 2015 payment adjustment period and performance feedback has been provided through the annual QRUR since 2013, for a subset of groups that had 20 or more eligible professionals, and to all groups in the annual QRUR since 2014 and mid-year QRUR since 2015. The MSPB measure has been included since the 2016 payment adjustment period and in annual QRUR since 2014 and the mid-year QRUR since 2015, or its hospital-specified version, which has been a part of the Hospital VBP Program since 2015. CMS does not propose any changes to the methodologies for payment standardization, risk adjustment, and specialty adjustment for these measures and will continue to provide performance results in the form of confidential feedback for informational purposes only. For more information about these policies, see the CY 2017 QPP final rule (81 FR	***CMS finalized this policy as proposed for the 2018 MIPS performance period and future performance periods*** (p. 282). CMS intends to provide performance feedback on the MSPB and Total Per Capita Cost measures by July 1, 2018, consistent with section 1848(q)(12) of the Act. Despite widespread concerns expressed about the use of these two measures, CMS believes they cover a large number of patients and provide an important measurement of clinician contribution to the overall population that a clinician encounters. CMS clarifies that it will continue to refine these measures for improvement. If it finds that episode-based measures would be an appropriate replacement for both of these measures, it will address that issue in future rulemaking. However, at this time, CMS believes that these two measures are tested and reliable for Medicare populations and are therefore the best measures available for the cost performance category. In response to requests that CMS exclude Part B drugs from the cost measures because Part D drugs are excluded, CMS stated that it does not believe it would be appropriate to remove the cost of Medicare Part B drugs from these measures when other services that are ordered, but not performed by clinicians, such as laboratory tests or diagnostic imaging, are included. Although clinicians play a similar role in prescribing Part D drugs, and Part D drugs can also be a significant contributor to the overall cost of care, there are technical challenges that would need to be

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	77164 through 77171).	addressed to integrate Part D drug costs since Section 1848(q)(2)(B)(ii) of the Act requires CMS, to the extent feasible and applicable, to account for the cost of drugs under Medicare Part D as part of cost measurement under MIPS. CMS will continue to explore the addition of this data in cost measures.
	Episode-Based Measures. For the 2018 MIPS performance period, CMS does not propose to include in the cost performance category the 10 episode-based measures that it adopted for the 2017 MIPS performance period. CMS will instead will work to develop new episode-based measures, with significant clinician input, for future performance periods. It plans to continue to provide confidential performance feedback to clinicians on episode-based measures as appropriate in order to increase familiarity with the concept of episode-based measurement, as well as the specific episodes that could be included in this category in the future.	CMS maintains its policy not to include in the cost category the 10 episode-based measures that it adopted for the 2017 performance period (p. 289). Instead, CMS will focus on its more recent work to develop episode-based costs measures under a more comprehensive approach that better incorporates clinical stakeholder input. CMS is conducting a rigorous process to ensure that any new episode-based cost measure is rigorously reviewed before implementation and believes this most recent effort to develop episode-based cost measures goes beyond the typical testing associated with many performance measures. CMS recently provided an initial opportunity for clinicians to review their performance based on the new episode-based measures through confidential feedback reports and intends to provide feedback on newly developed measures as they become available in a new format around summer 2018. CMS will endeavor to have as many episode-based measures available as possible for the 2019 MIPS performance period, but will continue to develop measures for potential consideration in the more distant future. CMS also clarifies that all episode-based cost measures that will be included in the program would be included in a future proposed rule, and CMS would discuss the assessment and testing of the measures at the time of their proposal. CMS also will consider the opportunity to submit measures that have been or may be adopted for the cost performance category for NQF endorsement and to the MAP review process in the future. Because CMS is focusing on development of new episode-based measures, its feedback on episode-based measures that were previously developed (i.e., the 10 episode-based measures finalized for the 2017 performance year) will discontinue after 2017, as these measures would no longer be maintained or reflect changes in diagnostic and procedural coding.

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		CMS also clarified here that episode-based measures may include Part B drug costs if clinically appropriate. However, CMS once again recognized requests that episode-based measures be developed in a way that considers all drug costs (Part B and D) in the same manner and reiterated its interest in continuing to explore methods to add Part D drug costs into cost measures in the future. Finally, CMS notes that it is open to considering other types of measures for use in the cost performance category. If an episode based measure or cost measure were to be created by an external stakeholder, CMS may consider it for inclusion in the program along the same criteria that it has used to develop and refine other cost measures.
	Attribution. CMS proposes to add CPT codes 99487 and 99489, both describing complex chronic care management, to the list of primary care services used to attribute patients under the Total Per Capita cost measure. The services described by these codes are substantially similar to those described by the chronic care management code (CPT code 99490) that CMS previously added to the list of primary care services beginning with the 2017 performance period (along with the transitional care management codes or CPT codes 99495 and 99496). CMS does not propose any changes to the attribution methods for the MSPB measure. CMS does not propose any changes for how it attributes cost measures to individual and group reporters.	***CMS finalized its proposal to add CPT codes 99487 and 99489 to the list of primary care services used to attribute patients under Total Per Capita Cost measure*** (p. 293). In response to a concern about the impact of adding the complex chronic care management codes on palliative care physicians-- who often bill for the services, but serve in a consulting role as opposed to serving as a primary care clinician—CMS clarified that the attribution model that assigns patients on the basis of a plurality of services would not assign patients for the purposes of the Total Per Capita Cost measure on the basis of a single visit, unless that patient had also not seen a primary care clinician during the year. CMS also clarified that services provided in POS 31 (skilled nursing home facility or SNF) are not included in the definition of primary care services used for the Total Per Capita Cost measure, but services provided in POS 32 (nursing facilities or NFs) are. CMS explained that patients in POS 31 require more frequent practitioner visits—often from 1 to 3 times a week. In contrast, patients in POS 32 are almost always permanent residents and generally receive their primary care services in the facility for the duration of their life. On the other hand, patients in POS 32 are usually seen every 30 to 60 days unless medical necessity dictates otherwise. CMS believes this distinction is important enough to treat these sites of service differently in terms of attribution for the Total Per Capita Cost measure. In response to requests that CMS delay implementation of cost measures until it has implemented patient relationship code, CMS noted that the

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		statute requires it to include the cost performance category in the MIPS program, and thus, it cannot delay the use of cost measures in MIPS until after the patient relationship codes have been implemented (as a reminder, CMS recently finalized in the 2018 MPFS Final Rule, in accordance with Section 1848(r)(4) of the Act, that clinicians may voluntarily report these codes beginning January 1, 2018). However, CMS may consider future changes to its attribution methods for cost measures based on the patient relationship codes that will be reported on claims. CMS will continue to work to improve attribution methods as it develops cost measures. CMS clarifies that it does not rely on a single attribution method - instead the method is linked to a measure in an attempt to best identify the clinician who may have influenced the spending for a patient. As CMS continues its work to develop episode-based measures and refine the two cost measures included for the 2018 MIPS performance period, CMS will work to explain the methodology for attribution and how it works in relation to the measure and the scoring methodology.
	Reliability. CMS does not propose any adjustments to its reliability policies. In the 2017 QPP Final Rule (81 FR 77169 through 77170), CMS finalized a reliability threshold of 0.4 for measures in the cost performance category.	CMS maintains this policy (p. 293). CMS will continue to evaluate reliability and take the public's comments into consideration as it develops new measures to ensure they meet an appropriate standard.
	Incorporation of Cost Measures with SES or Risk Adjustment. Both measures proposed for inclusion in the cost performance category for the 2018 MIPS performance period are risk adjusted at the measure level. Although the risk adjustment of the two measures is not identical, in both cases it is used to recognize the higher risk associated with demographic factors (e.g., age) or certain clinical conditions. Nevertheless, CMS recognizes that the risks accounted for with these adjustments are not the only potential attributes that could lead to a higher cost patient. While CMS did not propose any changes to address risk adjustment for cost measures in this rule, it continues to believe this is an important issue and it will be considered carefully in the development of future cost measures and for the overall cost performance category.	CMS maintains these policies (p. 294).
	Incorporation of Cost Measures with ICD-10 Impacts. In this rule, CMS discusses its proposal to assess performance on any measures impacted by ICD-10 updates based only on the first 9 months of the 12-month performance period. Because the Total Per Capita Cost and MSPB measures include costs from all Medicare Part A and B services, regardless of the specific ICD-10 codes that are used on claims, and do	CMS maintains this policy (p. 295). However, as CMS continues its plans to expand cost measures to incorporate episode-based measures, ICD-10 changes could become important since episode-based measures may be opened (triggered) by and may assign services based on ICD-10 codes. Thus, a change to ICD-10 coding could have a significant effect on an episode-based measure. As such, changes to ICD-10 codes will be

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	not assign patients based on ICD-10, CMS does not anticipate that any measures for the cost performance category would be affected by this ICD-10 issue during the 2018 MIPS performance period.	incorporated into the measure specifications on a regular basis through the measure maintenance process.
	Application of Measures to Non-Patient Facing MIPS Eligible Clinicians. CMS does not propose any changes to its previously finalized policy that it will attribute cost measures to non-patient facing MIPS eligible clinicians who have sufficient case volume, in accordance with the attribution methodology. However, CMS continues to consider opportunities to develop alternative cost measures for non-patient facing clinicians.	CMS maintains this policy (p. 296). CMS believes that non-patient facing clinicians are an integral part of the care team and that their services do contribute to overall costs, but at this time believes it better to focus on the development of a comprehensive system of episode-based measures which focus on the role of patient-facing clinicians. Since CMS is not finalizing any alternative cost measures for non-patient facing MIPS eligible clinicians or groups, they are unlikely to be attributed any cost measures (or have an insufficient number attributed to them) and thus, would not be scored on the cost performance category under MIPS. CMS will continue to explore methods to incorporate non-patient facing clinicians into the cost performance category in the future.
	Facility-Based Measurement as it Relates to the Cost Performance Category. In the scoring section of this rule, CMS discusses its proposal to assess clinicians who meet certain requirements and elect participation based on the performance of their associated hospital in the Hospital VBP Program.	CMS refers readers to the scoring section of this final rule (p. 655).
Improvement Activity Criteria	*Background.* CMS does not propose to change these policies. However, it will continue to consider including emerging certified health IT capabilities as part of activities within the Improvement Activities Inventory in future years. CMS also seeks comment on how it might provide flexibility for MIPS eligible clinicians to effectively demonstrate improvement through health IT usage while also measuring such improvement.	CMS received many comments on this topic and will take them into consideration for future rulemaking. (p. 299)
	Contribution to Final Score. CMS proposes that the term "recognized" be accepted as equivalent to the term "certified." Further, CMS proposes revisions to the regulatory text at §414.1380(b)(3)(iv) to provide that a MIPS eligible clinician or group in a practice that is certified or recognized as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, receives full credit (i.e., the highest score for the category, which is 40 points) for performance on the improvement activities performance category. CMS proposes new, high-weighted activities in Table F. CMS will take suggested additional criteria into consideration for designating high-weighted activities in future rulemaking.	***CMS finalized its proposals: (1) that the term "recognized" be accepted as equivalent to the term "certified" when referring to the requirements for a patient-centered medical home to receive full credit for the improvement activities performance category for MIPS; and (2) to update §414.1380(b)(3)(iv) to reflect this change.*** (p. 303) Table F in the Appendix outlines the finalized new activities, while Table G outlines finalized changes to existing improvement activities.

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	Submission Mechanisms. CMS proposes to continue this policy into future years and proposes to modify the regulatory text at §414.1360 to reflect this. CMS proposes to generally apply its previously finalized and proposed group policies to virtual groups.	***CMS finalized its proposals, with clarification, to continue previously established policies for future years. Specifically: (1) for purposes of MIPS Year 2 and future years, MIPS eligible clinicians or groups must submit data on MIPS improvement activities in one of the following manners: via qualified registries; EHR submission mechanisms; QCDR, CMS Web Interface; or attestation. CMS also finalized that (2) for activities that are performed for at least a continuous 90 days during the performance period, MIPS eligible clinicians must submit a "yes" response for activities within the Improvement Activities Inventory; and (3) that §414.1360 will be updated to reflect these changes.*** (p. 308)
	CMS proposes to revise §414.1325(d) for purposes of the 2020 MIPS payment year and future years to allow individual MIPS eligible clinicians and groups to submit measures and activities, as applicable, via as many submission mechanisms as necessary to meet the requirements of the quality, improvement activities, or ACI performance categories.	***CMS finalized its proposal, with modification, to revise §414.1325(d) for purposes of the 2021 MIPS payment year and future years to allow individual MIPS eligible clinicians and groups to submit measures and activities, as applicable, via as many submission mechanisms as necessary to meet the requirements of the quality, improvement activities, or advancing care information performance categories.*** (p. 214) See the Submission Mechanism section of this document for a discussion of this finalized proposal.
	CMS proposes to generally apply its previously finalized and proposed group policies to virtual groups.	***CMS finalized its proposal to generally apply its group policies to virtual groups.*** (p. 214) See section on Application of MIPS Group Policies to Virtual Groups for a discussion of this finalized proposal.
	Also, while CMS does not propose any changes to this policy, it requests comment on whether it should establish a minimum threshold (for example, 50%) of the clinicians (NPIs) that must complete an improvement activity in order for the entire group (TIN) to receive credit in the improvement activities performance category in future years. In addition, CMS requests comments on recommended minimum threshold percentages and whether it should establish different thresholds based on the size of the group. CMS requests comments on how to set this threshold while maintaining the goal of promoting greater participation in an improvement activity.	CMS received many comments on this topic and will take them into consideration for future policies. (p. 310)
	CMS seeks comment on how it could measure performance and improvement, and is especially interested in ways to measure performance without imposing additional burden on eligible clinicians, such as by using data captured in eligible clinicians' daily work.	CMS received many comments on this topic and will take them into consideration for future policies. (p. 310)
	Submission Criteria. CMS proposes to generally apply its previously	***CMS finalized its proposal to generally apply group policies to virtual***

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	finalized and proposed group policies to virtual groups.	***groups.*** See section on Application of MIPS Group Policies to Virtual Groups for a discussion of this finalized proposal.
	CMS proposes to revise §414.1380(b)(3)(x) to provide that for the 2020 MIPS payment year and future years, to receive full credit as a certified or recognized patient-centered medical home or comparable specialty practice, at least 50% of the practice sites within the TIN must be recognized as a patient-centered medical home or comparable specialty practice. CMS welcomes suggestions on an appropriate threshold for the number of NPIs within the TIN that must be recognized as a certified patient-centered medical home or comparable specialty practice to receive full credit in the improvement activities performance category.	***CMS finalized its proposals with clarification. Specifically, CMS finalized that for the 2020 MIPS payment year and future years, to receive full credit as a certified or recognized patient-centered medical home or comparable specialty practice, at least 50% of the practice sites within the TIN must be recognized as a patient-centered medical home or comparable specialty practice.*** (p. 323) CMS clarified that a practice site is the physical location where services are delivered. CMS finalized its proposals to add §414.1380(b)(3)(x) to reflect these changes.
	CMS proposes that MIPS eligible clinicians in practices that have been randomized to the control group in the CPC+ APM would receive full credit as a medical home model, and therefore a certified patient-centered medical home, for the improvement activities performance category. CMS requests comments on these proposals.	***CMS did not finalize its proposal given public comments received and developments in the CPC+ Model.*** (p. 325)
	Required Period of Time for Performing an Activity. CMS proposes to generally apply its previously finalized and proposed group policies to virtual groups. CMS does not propose any changes to the required period of time for performing an activity for the improvement activities performance category in this proposed rule.	CMS received many comments on this topic and will take them into consideration for future rulemaking.
	Application of Improvement Activities to Non-Patient Facing Individual MIPS Eligible Clinicians and Groups. CMS does not propose any changes to the application of improvement activities to non-patient facing individual MIPS eligible clinicians and groups for the improvement activities performance category in this proposed rule.	CMS received a few comments on this topic and will take them into consideration for future rulemaking.
	Special Consideration for Small, Rural, or Health Professional Shortage Areas Practices. CMS does not propose any changes to the special consideration for small, rural, or health professional shortage areas practices for the improvement activities performance category in this proposed rule.	CMS received many comments on this topic and will take them into consideration for future rulemaking.
	Improvement Activities Subcategories. CMS does not propose any changes to the improvement activities subcategories for the improvement activities performance category in this proposed rule.	CMS received a few comments on this topic and will take them into consideration for future rulemaking.

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	Proposed Approach on the Annual Call for Activities Process for Adding New Activities. CMS proposes new activities and changes to the Improvement Activities Inventory in Tables F and G of this proposed rule. CMS proposes to formalize an Annual Call for Activities process for adding possible new activities to the Improvement Activities Inventory. CMS proposes that individual MIPS eligible clinicians or groups and other relevant stakeholders may recommend activities for potential inclusion in the Improvement Activities Inventory via a similar nomination form utilized in the transition year of MIPS found on the QPP website at www.qpp.cms.gov. CMS requests comment on this proposed annual Call for Activities process.	As noted above, Table F in the Appendix outlines the finalized new activities, while Table G outlines finalized changes to existing improvement activities. ***CMS finalized its proposal, as proposed, to formalize the Annual Call for Activities process for Quality Payment Program Year 3 and future years***. (p. 338)
	Criteria for Nominating New Improvement Activities for the Annual Call for Activities. CMS proposes for the QPP Year 2 and future years that stakeholders would apply one or more criteria when submitting improvement activities in response to the Annual Call for Activities. CMS requests comments on this proposal.	***CMS finalized with modification, for the QPP Year 3 and future years, that stakeholders should apply one or more of the criteria when submitting improvement activities in response to the Annual Call for Activities.*** In addition to the criteria listed in the proposed rule for nominating new improvement activities for the Annual Call for Activities policy CMS is modifying and expanding the proposed criteria list to also include: (1) improvement activities that focus on meaningful actions from the person and family's point of view, and (2) improvement activities that support the patient's family or personal caregiver. The finalized list of criteria for submitting improvement activities in response to the Annual Call for Activities is as follows: • Relevance to an existing improvement activities subcategory (or a proposed new subcategory); • Importance of an activity toward achieving improved beneficiary health outcome; • Importance of an activity that could lead to improvement in practice to reduce health care disparities; • Aligned with patient-centered medical homes; • Focus on meaningful actions from the person and family's point of view; • Support the patient's family or personal caregiver; • Activities that may be considered for an advancing care information bonus; • Representative of activities that multiple individual MIPS eligible clinicians or groups could perform (for example, primary care, specialty care); • Feasible to implement, recognizing importance in minimizing burden,

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		especially for small practices, practices in rural areas, or in areas designated as geographic HPSAs by HRSA; • Evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes; or • CMS is able to validate the activity. (p. 340)
	Submission Timeline for Nominating New Improvement Activities for the Annual Call for Activities. CMS proposes to accept submissions for prospective improvement activities at any time during the performance period for the Annual Call for Activities and create an Improvement Activities under Review (IAUR) list. CMS proposes that for the Annual Call for Activities, only activities submitted by March 1 would be considered for inclusion in the Improvement Activities Inventory for the performance periods occurring in the following calendar year. CMS also proposes that it will add new improvement activities to the inventory through notice-and-comment rulemaking. In future years, CMS anticipates developing a process and establishing criteria for identifying activities for removal from the Improvement Activities Inventory through the Annual Call for Activities process. CMS requests comments on what criteria should be used to identify improvement activities for removal from the Improvement Activities Inventory.	***CMS did not receive any public comments on these proposals, thus it finalized its proposals, as proposed, to: (1) accept submissions for prospective improvement activities at any time during the performance period for the Annual Call for Activities and create an Improvement Activities under Review (IAUR) list; (2) only consider prospective activities submitted by March 1 for inclusion in the Improvement Activities Inventory for the performance periods occurring in the following calendar year; and (3) add new improvement activities to the inventory through notice-and-comment rulemaking.*** (p. 343) CMS received a few comments on this topic and will take them into consideration for future rulemaking.
	Approach for Adding New Subcategories. CMS does not propose any changes to the approach for adding new subcategories for the improvement activities performance category in this proposed rule. However, CMS proposes that in future years of the QPP, it will add new improvement activities subcategories through notice-and-comment rulemaking. In addition, CMS seeks comments on new improvement activities subcategories. CMS seeks suggestions on how a health IT subcategory within the improvement activities performance category could be structured to afford MIPS eligible clinicians with flexible opportunities to gain experience in using CEHRT and other health IT to improve their practice. For example, *should the current policies where improvement activities earn bonus points within the ACI performance category be enhanced? Are there additional policies that should be explored in future rulemaking?* CMS welcomes public comment on this potential health IT subcategory.	CMS received many comments on these topics and will take them into consideration for future rulemaking.

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	CMS Study on Burdens Associated with Reporting Quality Measures. CMS is modifying the name of the study to the "CMS study on burdens associated with reporting quality measures" to more accurately reflect the purpose of the study. While CMS does not propose any changes to the study purpose, it proposes changes to the study participation credit and requirements sample size, how the study sample is categorized into groups, and the frequency of quality data submission, focus groups, and surveys. CMS proposes to increase the sample size for the performance periods occurring in 2018. CMS proposes that for QPP Year 2 and future years that study participants would be required to attend as frequently as four monthly surveys and focus group sessions throughout the year, but certain study participants would be able to attend less frequently. CMS also proposes for the QPP Year 2 and future years to offer study participants flexibility in their submissions so that they could submit once, as can occur in the MIPS program, and participate in study surveys and focus groups while still earning improvement activities credit. CMS requests comments on its study on burdens associated with reporting quality measures proposals regarding sample size for the performance periods occurring in 2018, study procedures for the performance periods occurring in 2018 and future years, and data submissions for the performance periods occurring in 2018 and future years.	***CMS finalized its proposals for the CY 2018 and beyond as proposed, to:*** *(1) modify the name of the study to the "CMS Study on Burdens Associated with Reporting Quality Measures"* (p. 350) *(2) increase the sample size for CY 2018* (see p. 347); *(3) require study participants to attend as frequently as four monthly surveys and focus group sessions throughout the year; and* (p. 350) *(4) for the QPP Year 2 and future years, offer study participants flexibility in their submissions such that they can submit all their quality measures data at once and participate in study surveys and focus groups while still earning improvement activities credit.* (p. 350) CMS will consider for future rulemaking further efforts to include proportionate HPSAs and minority patients in the recruitment and screening of the study participants. (p. 350) Further, CMS intends to make the results of the study public immediately after the end of the study year CY 2018 (summer 2019) to all study participants, relevant stakeholders, and on the CMS website. (p. 350)
Advancing Care Information (ACI) Performance Category	*Scoring.* MACRA requires that 25% of the MIPS final score is based on performance for the ACI performance category.	Consistent with the statute, ***for Year 2, the ACI performance category is 25% of the final score*** (p. 352). Tables 7 and 8 describe the 2018 performance period ACI performance category scoring methodology for both sets of ACI objectives and measures. Table 9 includes the 2015 Edition and 2014 Edition certification criteria required to meet both sets of ACI objectives and measures.
	Base Score. CMS does not propose any changes to the base score methodology.	No change

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	Performance Score. CMS does not propose to change the maximum performance score that a MIPS eligible clinician can earn; it remains at 90%.	No change
	CMS proposes if a MIPS eligible clinician fulfills the Immunization Registry Reporting Measure, the MIPS eligible clinician would earn 10 percentage points in the performance score. If a MIPS eligible clinician cannot fulfill the Immunization Registry Reporting Measure, CMS proposes that the MIPS eligible clinician could earn 5 percentage points in the performance score for each public health agency or clinical data registry to which the clinician reports for the following measures, up to a maximum of 10 percentage points: Syndromic Surveillance Reporting; Electronic Case Reporting; Public Health Registry Reporting; and Clinical Data Registry Reporting (or Syndromic Surveillance Reporting or Specialized Registry Reporting under the 2018 ACI Transition set).	In light of public comments, ***CMS finalized its proposal with modification***. Rather than awarding 5 percentage points in the performance score for each public health agency or clinical data registry that a MIPS eligible clinician reports to (for a maximum of 10 percentage points), ***CMS finalized that a MIPS eligible clinician may earn 10 percentage points in the performance score for reporting to any single public health agency or clinical data registry to meet any of the measures associated with the Public Health and Clinical Data Registry Reporting Objective (or any of the measures associated with the Public Health Reporting Objective of the 2018 Advancing Care Information Transition Objectives and Measures, for clinicians who choose to report on those measures), regardless of whether an immunization registry is available to the clinician***. A MIPS eligible clinician can earn only 10 percentage points in the performance score under this policy, no matter how many agencies or registries they report to. This policy will apply beginning with the 2018 performance period. (p. 355)
	Bonus Score. CMS proposes that a MIPS eligible clinician may only earn the bonus score of 5 percentage points for reporting to at least one additional public health agency or clinical data registry that is different from the agency/agencies or registry/or registries to which the MIPS eligible clinician reports to earn a performance score. CMS proposes that for the ACI Objectives and Measures, a bonus of 5 percentage points would be awarded if the MIPS eligible clinician reports "yes" for any one of the following measures associated with the Public Health and Clinical Data Registry Reporting objective: Syndromic Surveillance Reporting; Electronic Case Reporting; Public Health Registry Reporting; or Clinical Data Registry Reporting (or Syndromic Surveillance Reporting or Specialized Registry Reporting under the 2018 ACI Transition set). CMS proposes that to earn the bonus score, the MIPS eligible clinician must be in active engagement with one or more additional public health agencies or clinical data registries that is/are different from the agency or registry that they identified to earn a performance score.	***CMS finalized its proposal that a MIPS eligible clinician would not receive credit under both the performance score and bonus score for reporting to the same agency or registry.*** CMS will update the regulation text at §414.1380(b)(4)(C)(1) to reflect the change. (p. 358)
	Improvement Activities Bonus Score under the ACI Performance Category. CMS proposes to expand this policy beginning with the 2018 performance period by identifying additional improvement activities in Table 6 that would be eligible for the ACI performance category bonus	***CMS finalized with modifications the list of improvement activities shown in Table 6 that will be eligible for the ACI performance category bonus score beginning with the 2018 performance period if they are completed using CEHRT.*** (p. 360)

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	score if they are completed using CEHRT functionality. CMS invites comment on this proposal.	
	Performance Periods for the ACI Performance Category. CMS proposes the same policy for the ACI performance category for the performance period in 2019, QPP Year 3, and would accept a minimum of 90 consecutive days of data in CY 2019.	***CMS finalized its proposal to accept a minimum of 90 consecutive days of data in CY 2019***. CMS will revise the regulation text at §414.1320(d)(1) accordingly. (p. 371)
	Certification Requirements. CMS proposes that MIPS eligible clinicians may use EHR technology certified to either the 2014 or 2015 Edition certification criteria, or a combination of the two for the 2018 performance period. CMS proposes to amend §414.1305 to reflect this change.	***CMS finalized its proposal to allow the use of 2014 Edition or 2015 Edition CEHRT, or a combination of the two Editions, for the performance period in 2018***. (p. 376)
	CMS proposes to offer a bonus of 10 percentage points under the ACI performance category for MIPS eligible clinicians who report the ACI Objectives and Measures for the performance period in 2018 using only 2015 Edition CEHRT, and proposes to amend §414.1380(b)(4)C)(3) to reflect this change. CMS seeks comment on this proposed bonus; specifically, if the percentage of the bonus is appropriate, or whether it should be limited to new participants in MIPS and small practices.	***CMS will offer a one-time bonus of 10 percentage points under the ACI performance category for MIPS eligible clinicians who report the ACI Objectives and Measures for the performance period in CY 2018 using only 2015 Edition CEHRT.*** CMS will not limit the bonus to new participants. (p. 376) CMS will revise §§ 414.1305 and 414.1380(b)(4) of the regulation text to reflect these policies. (p. 376)
	Scoring Methodology Considerations. CMS proposes to modify its existing policy such that it would base its estimation of physicians who are meaningful EHR users for a MIPS payment year on data from the performance period that occurs four years before the MIPS payment year.	***CMS finalized its proposals***. CMS' ability to implement this policy will be dependent on the availability of data from the performance period that occurs 4 years before the MIPS payment year. (p. 382)
	Advancing Care Information Objectives and Measures Specifications. CMS proposes to allow MIPS eligible clinicians and groups to continue to count active engagement in electronic public health reporting with specialized registries. Specifically, CMS proposes to allow these registries to be counted for purposes of reporting the Public Health Registry Reporting Measure or the Clinical Data Registry Reporting Measure beginning with the 2018 performance period.	***CMS finalized its proposals with one modification to the description of the Syndromic Surveillance Reporting Measure, which now reads: The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.*** (p. 392) See Appendix A for all of the finalized changes to the ACI Objectives and Measures. Given commenter confusion by CMS' proposal related to specialized registries and active engagement option 3, production, believing that the only way to receive credit for the Public Health Agency and Clinical Data Registry Reporting Objective is through the production option, ***CMS clarified that MIPS eligible clinicians may fulfill the Public Health Agency and Clinical Data Registry Reporting Objective or the Public Health***

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		Reporting Objective through any of the active engagement options as described at 80 FR 62818-62819: completed registration to submit data; testing and validation; or production. (p. 389) CMS stated that its proposal pertained to MIPS eligible clinicians who choose to use option 3, production, for specialized registries.
	2017 and 2018 Advancing Care Information Transition Objectives and Measures Specifications. CMS proposes to make several modifications identified and described in Appendix B of this summary to the 2017 Advancing Care Information Transition Objectives and Measures for the ACI performance category of MIPS for the 2017 and 2018 performance periods.	***CMS finalized its proposals***. (p. 392) See Appendix B for all of the finalized changes to the 2017 and 2018 ACI Transition Objectives and Measures. Given commenter confusion by CMS' proposal related to specialized registries and active engagement option 3, production, believing that the only way to receive credit for the Public Health Agency and Clinical Data Registry Reporting Objective is through the production option, ***CMS clarified that MIPS eligible clinicians may fulfill the Public Health Agency and Clinical Data Registry Reporting Objective or the Public Health Reporting Objective through any of the active engagement options as described at 80 FR 62818-62819: completed registration to submit data; testing and validation; or production.*** (p. 389) CMS stated that its proposal pertained to MIPS eligible clinicians who choose to use option 3, production, for specialized registries.
	Exclusions. CMS proposes to add exclusions to the measures associated with the Health Information Exchange and Electronic Prescribing objectives required for the base score, which it proposes would apply beginning with the 2017 performance period (see Appendix A and B of this summary for the exclusions).	***CMS finalized its proposals.*** (p. 402) The exclusions apply beginning with the 2017 performance period. See Appendix A and B of this summary for the exclusions.
	21st Century Cures Act. CMS believes that the general exceptions described under sections 1848(a)(7)(B) and (D) of the Act are applicable under the MIPS program, and proposes to implement these provisions as applied to assessments of MIPS eligible clinicians under section 1848(q) of the Act with respect to the ACI performance category.	***CMS finalized its policies in this section, as proposed***. See below for details.
	MIPS Eligible Clinicians Facing a Significant Hardship. CMS proposes to rely on section 1848(o)(2)(D) of the Act rather than section 1848(q)(5)(F) of the Act to provide for significant hardship exceptions under the ACI performance category under MIPS. CMS proposes not to apply the 5-year limitation under section 1848(a)(7)(B) of the Act to significant hardship exceptions for the ACI performance category under MIPS, which CMS believes is an appropriate application of section 1848(a)(7)(B) to MIPS eligible clinicians due to	***CMS finalized its policy as proposed.*** (p. 409)

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	CMS' desire to reduce clinician burden, promote the greatest level of participation in the MIPS program, and maintain consistency with the policies established in the 2017 QPP final rule. CMS solicits comments on the proposed use of the authority provided in the 21st Century Cures Act in section 1848(o)(2)(D) of the Act as it relates to application of significant hardship exceptions under MIPS and the proposal not to apply a 5-year limit to such exceptions.	
	Significant Hardship Exception for MIPS Eligible Clinicians in Small Practices. CMS proposes a significant hardship exception for the ACI performance category for MIPS eligible clinicians who are in small practices under the authority in section 1848(o)(2)(D) of the Act, as amended by section 4002(b)(1)(B) of the 21st Century Cures Act. CMS proposes this exception would be available beginning with the 2018 performance period and 2020 MIPS payment year. CMS proposes to reweight the ACI performance category to 0% of the MIPS final score for MIPS eligible clinicians who qualify for this hardship exception. CMS also proposes MIPS eligible clinicians seeking this exception must demonstrate in the application that there are overwhelming barriers that prevent the MIPS eligible clinician from complying with the requirements for the ACI performance category.	***CMS finalized its policy as proposed***. (p. 415)
	Hospital-Based MIPS Eligible Clinicians. CMS proposes to now rely on section 1848(o)(2)(D) for exceptions for hospital-based MIPS eligible clinicians under the ACI performance category.	***CMS finalized its policy as proposed***. (p. 418) CMS will amend §414.1380(c)(1) and (2) of the regulation text to reflect this policy.
	Ambulatory Surgical Center (ASC)-Based MIPS Eligible Clinicians. CMS proposes to define at §414.1305 an ASC-based MIPS eligible clinician as a MIPS eligible clinician who furnishes 75% or more of his or her covered professional services in sites of service identified by the Place of Service (POS) code 24 used in the HIPAA standard transaction based on claims for a period prior to the performance period as specified by us. CMS requests comments on this proposal and solicits comments as to whether other POS codes should be used to identify a MIPS eligible clinician's ASC-based status or if an alternative methodology should be used. CMS proposes to use claims with dates of service between September 1 of the calendar year 2 years preceding the performance period through August 31 of the calendar year preceding the performance period, but in the event it is not operationally feasible to use claims from this time period, CMS would use a 12-month period as close as practicable to this time period. CMS proposes this timeline to allow the agency to notify	***CMS finalized its policy as proposed***. (p. 422) CMS will amend §414.1305 and §414.1380(c)(1) and (2) to reflect this policy.

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	MIPS eligible clinicians of their ASC-based status prior to the start of the performance period and to align with the hospital-based MIPS eligible clinician determination period. For MIPS eligible clinicians who CMS determines are ASC-based, CMS proposes to assign a 0% weighting to the ACI performance category in the MIPS final score for the MIPS payment year. However, if a MIPS eligible clinician who is determined ASC-based chooses to report on the ACI measures for the performance period for the MIPS payment year for which they are determined ASC-based, CMS proposes they would be scored on the ACI performance category like all other MIPS eligible clinicians, and the ACI performance category would be given the weighting prescribed by section 1848(q)(5)(E) of the Act regardless of their ACI performance category score. CMS proposes these ASC-based policies would apply beginning with the 2017 performance period/2019 MIPS payment year, and would amend §414.1380(c)(1) and (2) of the regulation text to reflect these proposals. CMS requests comments on these proposals.	
	Exception for MIPS Eligible Clinicians Using Decertified EHR Technology. CMS proposes that a MIPS eligible clinician may demonstrate through an application process that reporting on the measures specified for the ACI performance category is not possible because the CEHRT used by the MIPS eligible clinician has been decertified under ONC's Health IT Certification Program. CMS proposes that if the MIPS eligible clinician's demonstration is successful and an exception is granted, CMS would assign a 0% weighting to the ACI performance category in the MIPS final score for the MIPS payment year. CMS proposes this exception would be available beginning with the CY 2018 performance period and the 2020 MIPS payment year. CMS proposes that a MIPS eligible clinician may qualify for this exception if their CEHRT was decertified either during the performance period for the MIPS payment year or during the calendar year preceding the performance period for the MIPS payment year. In addition, CMS proposes that the MIPS eligible clinician must demonstrate in their application and through supporting documentation if available that the MIPS eligible clinician made a good faith effort to adopt and implement another CEHRT in advance of the performance period. CMS proposes a MIPS eligible clinician seeking to qualify for this exception would submit an application in the form and manner specified by the agency by	***CMS finalized its policy as proposed***. (p. 425) CMS will amend §414.1380(c)(1) and (2) of the regulation text to reflect this policy.

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	December 31st of the performance period, or a later date specified by the agency. CMS proposes to amend §414.1380(c)(1) and (2) of the regulation text to reflect these proposals, and seeks comments on these proposals.	
	Hospital-Based MIPS Eligible Clinicians. CMS proposes to modify its policy to include covered professional services furnished by MIPS eligible clinicians in an off-campus-outpatient hospital (POS 19) in the definition of hospital-based MIPS eligible clinician. CMS proposes to add POS 19 to its existing definition of a hospital-based MIPS eligible clinician beginning with the performance period in 2018.	***CMS finalized its policy as proposed.*** (p. 427) CMS will monitor MIPS participation of clinicians who practice in these settings to determine if they are able to meet the requirements of the ACI performance category and consider automatic reweighting in the future.
	Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists. CMS proposes the same policy for NPs, PAs, CRNAs, and CNSs for the 2018 performance period, but intends to evaluate the participation of these MIPS eligible clinicians in the ACI performance category for 2017 and expects to adopt measures applicable and available to them in subsequent years. CMS seeks comment on how the ACI performance category could be applied to NPs, PAs, CRNAs, and CNSs in future years of MIPS, and the types of measures that would be applicable and available to these types of MIPS eligible clinicians.	CMS did not address this section in the final rule or otherwise acknowledge receipt of comments.
	Scoring for MIPS Eligible Clinicians in Group Practices. In any of the situations described in the sections above, CMS would assign a 0% weighting to the ACI performance category in the MIPS final score for the MIPS payment year if the MIPS eligible clinician meets certain specified requirements for this weighting.	CMS will take comments it received into consideration and may address the issues raised in future rulemaking. (p. 430)
	Timeline for Submission of Reweighting Applications. CMS proposes to change the submission deadline for the application as the agency believes that aligning the data submission deadline with the reweighting application deadline could disadvantage MIPS eligible clinicians. CMS proposes to change the submission deadline for the 2017 performance period to December 31, 2017, or a later date specified by the agency, which would help MIPS eligible clinicians learn whether their application is approved prior to the data submission deadline for the 2017 performance period, March 31, 2018. CMS proposes that the submission deadline for the 2018 performance period will be December 31, 2018, or a later date as specified by the agency, which would help MIPS eligible clinicians by allowing them to learn whether their application is approved prior to the data submission	***CMS finalized its policy, as proposed.*** (p. 432) The submission of QPP Hardship Exception Applications began during the 2017 performance period (in August 2017) and will close at the end of the calendar year 2017.

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	deadline for the CY 2018 performance period, March 31, 2019.	
APM Scoring Standard for MIPS Eligible Clinicians in MIPS APMs		
General	CMS proposes to adopt the same generally applicable MIPS policies for the APM Scoring Standard proposed elsewhere in the rule and will "treat the APM Entity group as the group for purposes of MIPS" unless it proposes to include a proposal to adopt a unique policy for the APM Scoring Standard.	CMS generally reiterated these policies (p. 433).
	CMS seeks comment on whether there are potential conflicts or inconsistences between the generally applicable MIPS policies and those under the APM Scoring Standard, "particularly where these could impact our goals to reduce duplicative and potentially incongruous reporting requirements and performance evaluations that could undermine our ability to test or evaluate MIPS APMs, or whether certain generally applicable MIPS policies should be made explicitly applicable to the APM scoring standard."	CMS made no mention on comments received regarding their request for information on whether there are potential conflicts or inconsistences between the generally applicable MIPS policies and those under the APM Scoring Standard outside of responses to the more specific policies listed below.
Assessment Dates for Inclusion of MIPS Eligible Clinicians in APM Entity Groups Under the APM Scoring Standard	CMS previously finalized that an APM Entity group will be made up of the eligible clinicians who are on the Participation List of the APM Entity on at least one of three dates: March 31, June 30, and August 31. CMS proposes to add a fourth assessment date of December 31 "to identify those MIPS eligible clinicians who participate in a full TIN APM."	***CMS finalized this policy as proposed*** (p. 442). CMS received comments requesting that it extend the policy to all MIPS APM participants (not just those who participating in a full TIN APM). CMS did not change it's policy as it believes "it is appropriate to ensure that the APM scoring standard only applies for those who are genuinely committed to participating in MIPS APMs (p. 441).
	CMS does not propose to utilize the fourth assessment date of December 31 for purposes of making QP determinations.	CMS received comments asking for the December 31st snapshot date to be utilized for making QP determinations but declined to do so (p. 440). CMS also received comments asking that the policy be made retroactive to 2017 but replied that the notice and comment policies prohibit them from doing that without specific and articulable authority and reason, which it does not believe exists here (p. 439).
Calculating MIPS APM Performance Category Scores	**Cost Performance Category**. CMS proposes to continue to waive the weighting of the Cost Performance Category under the APM Standard for Payment Year 2020 forward.	***CMS finalized its proposal to weight the Cost Performance Category for MIPS APMs to zero for the 2018 performance period (2020 payment year)*** (p. 446). CMS continues to believe that scoring the Cost Performance Category for MIPS APMs is unnecessary and could potentially create conflicting incentives for MIPS APM participants (p. 445).
	While CMS is required to incorporate performance improvement in into	***CMS finalized this proposal*** (p. 447).

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	the Cost Performance Category in Performance Year 2018, CMS also proposes to utilize its waiver authority to waive the requirement that it take into account improvement in performance scores for the Cost Performance Category under the APM Scoring Standard.	
	Quality Performance Category <u>Shared Savings Program and Next Generation ACO Models</u>: Under its APM Scoring Standard provisions, CMS previously finalized that participants in the Shared Savings Program and the Next Generation ACO Model would be assessed for the Quality Performance Category exclusively on quality measures submitted using the CMS Web Interface. However, Shared Savings Program and Next Generation ACO Model participants are not currently assessed under the APM Scoring Standard on any additional quality performance data otherwise submitted under those models via mechanisms other than the CMS Web Interface.	
	CAHPS For ACOs. CMS proposes to score the CAHPS for ACOs survey under the APM Scoring Standard beginning in the 2018 performance year for participants in the Shared Savings Program and Next Generation ACO Model.	***CMS finalized its proposal*** (p. 452).
	Calculation of Quality Scores. CMS proposes to not subject MIPS APM Web Interface reporters to the otherwise implemented 3 point floor because it does not believe it needs to apply a transition year policy to eligible clinicians participating in previously established MIPS APMs,	***CMS received no comments on this proposal and finalized it without modification*** (p. 452).
	Incentive to Report High Priority Measures. CMS previously finalized the application of bonus points on the finalized set of measures reportable through the Web Interface: two bonus points for reporting two or more outcome or patient experience measures and one bonus point for reporting any other high priority measure (beyond the first high priority measure). For Payment Year 2020 and going forward, CMS proposes that APM Entities in the Shared Savings Program and Next Generation ACO Models may receive bonus points under the APM Scoring standard for submitting the CAHPS for ACOs survey. CMS reiterated that in MIPS APMs, MIPS eligible clinicians are still subject to the 10% cap on bonus points for reporting high priority measures and that APM Entities reporting through the CMS Web Interface will only receive bonus points if they submit a high priority measure with a performance rate that is greater than zero, provided that the measure meets the case minimum requirements	***CMS received no comments on this proposal and finalized it without modification*** (p. 453).

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	CMS proposes to incorporate the same improvement methodology and total performance quality percent score for quality measures submitted via the CMS Web Interface as for all MIPS measures and eligible clinicians.	***CMS finalized its proposal*** (p. 454).
	Other MIPS APMs CMS proposes to define "Other MIPS APMs" as all MIPS APMs that do not require reporting through the CMS Web Interface.	***CMS finalized its definition of Other MIPS APMs as proposed*** (p. 456).
	In order to avoid conflicting incentives or quality reporting requirements and due to operational constraints in overcoming those issues, in the first year, CMS used its waiver authority to weight the Quality Performance Category for MIPS APMs under the APM Scoring Standard at zero. However, CMS stated its intention to use quality data submitted by APM Entities in the context of their MIPS APM to calculate a score under the Quality Performance Category of the APM Scoring Standard in the future. In this rule, CMS proposes to adopt quality measures for use under the APM Scoring Standard to calculate a MIPS Quality Performance Category score for MIPS APMs beginning in Performance Year 2018.	***CMS finalized its proposal to begin calculating a Quality Performance Score under the APM Scoring Standard for Other MIPS APMs*** (p. 459).
	CMS proposes to waive the requirement that it publish these measures on the "annual MIPS final list of quality measures" and instead to establish a "MIPS APM quality measure list" for purposes of the APM Scoring Standard.	***CMS finalized its proposal to include Other MIPS APM measures on a separate "MIPS APM quality measure list"*** (p. 462). CMS clarified that this will still occur in the context of notice-and-comment rulemaking, and it will not be scoring (under MIPS) performance for any measures not included on the MIPS APM quality measure list included in each year's rulemaking (i.e. measures added to an Other MIPS APM's measure set after the proposed rule has been published will not be scored under the APM Scoring Standard until they go through the notice-and-comment process (p. 461).
	Scoreable Other MIPS APM Measures. CMS proposes that it will only score measures that meet four criteria.	***CMS finalized its proposal to only include quality measures under the APM Scoring Standard Quality Performance Category for Other MIPS APMs that meet the four articulated criteria*** (p. 464).
	• Measures that are tied to payment as described under the terms of the APM	***CMS received no comments on this criterion and finalized it*** (p. 464).
	• Measures that are available for scoring near the close of the MIPS submission period	***CMS received no comments on this criterion and finalized it*** (p. 465).
	• Measures that have a minimum of 20 cases available for reporting: If a measure is reported by fails the 20 case minimum,	***CMS finalized this criterion*** and reiterated that APM Entities will not be penalized for not having fewer than 20 reportable cases but "instead will

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	there would be a null score for that measure and it would be removed from both the numerator and denominator (so that it would not negatively affect the APM Entity's Quality Performance Category score). CMS notes that if an APM Entity fails to meet the 20 case minimum on all available APM measures, the APM Entity would have its Quality Performance Category score reweighted to zero.	receive a null score for that particular measure, which will be removed from the numerator and denominator when calculating the total quality score (p. 466).
	• Measures that have an available benchmark: CMS expanded on the requirement and stated that the benchmark score used for the quality measure is the benchmark used in the MIPS APM for calculation of performance-based payments. If the APM does not produce a benchmark score, CMS would use the benchmark score for the measure that is used for the MIPS Quality Performance Category (outside of the APM Scoring Standard) for that performance year *if* the measure specifications are the same under the MIPS final measure list and the APM final measure list. If neither the APM nor MIPS has a benchmark available, the APM Entity that reported the measure would receive a null score for that measure's achievement points (and the measure would be removed from both the numerator and denominator of the Quality Performance Category percentage). Measures that are considered "pay for reporting" or which do not measure performance on a continuum of performance, CMS will consider the measure to be lacking a benchmark (p. 254).	***CMS finalized this criterion*** (p. 469). CMS clarified that pay-for-reporting measures will not be included as part of the Other MIPS APM Quality Performance Category under this criterion (i.e. pay-for-reporting measures have no available benchmark (p. 463)). CMS also received a comment that measures without a benchmark should receive a score at a certain floor (i.e. 3 points). CMS disagreed and noted that it believed this would be an inappropriate policy because "APM participants are required to report on all APM measures used in the MIPS APM, whereas eligible clinicians reporting under general MIPS are given the opportunity to choose six of the measures from the MIPS measure set" and believes "it would be unfair to require APM Entities to report on measures for which they are unable to achieve a score above three, which could significantly impact their total quality performance score" (p. 467). CMS noted, however, that it will use "any available benchmark" and does not anticipate that a lack of benchmarks will eliminate a significant number of measures from the APM Scoring Standard quality calculations (p. 468).
	Quality Required Number of Measures. CMS also proposes that the minimum number of required measures to be reported for the APM Scoring Standard would be the minimum number of quality measures that are required by the MIPS APM and are collected and available in time to be included. CMS proposes that if an APM Entity submits some, but not all, of the measures required by the MIPS APM (in time for inclusion), the APM Entity would receive points for the measures that were submitted, but zero for each remaining measure between the number of measures reported and the number of measures required by the APM that were available for scoring.	***CMS finalized this policy as proposed*** (p. 471).
	Quality Scoring Methodology. CMS proposes to use a decile distribution as in the finalized MIPS quality scoring methodology.	***CMS finalized its policy as proposed*** (p. 473).

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	CMS proposes that an APM Entity that reports on quality measures would receive between 1 and 10 achievement points for each measure (that can be reliably scored against a benchmark) up to the number of measures that are required to be reported by the APM. CMS does propose that under the APM Scoring Standard, APM Entities will be eligible to receive bonus points on high priority measures or measures submitted via CEHRT (e.g. end-to-end transmission) as otherwise proscribed under the MIPS scoring methodology. CMS proposes that the total number of awarded bonus points may not exceed 10% of the APM Entity's total available achievement points under the Quality Performance Category.	***CMS finalized its policy as proposed*** (p. 475).
	Quality Improvement Scoring. CMS proposes to begin scoring "improvement" in addition to "achievement" in the Quality Performance Category, including under the APM Scoring Standard.	***CMS finalized its proposal with clarification*** (p. 477). CMS noted that it inadvertently described the improvement scoring formula under the APM Scoring Standard in the proposed rule (although the cross-reference to the correct formula under the MIPS Scoring Standard was included) (p. 476). CMS clarified that the correct formula should read as follows: Quality Improvement Score= (Absolute Improvement/Previous Year Quality Performance Category Percent Score Prior to Bonus Points)*10
	Improvement Activities Performance Category. For 2017, CMS finalized that for all MIPS APMs, CMS will assign the same improvement activities score to each APM Entity based on the activities involved with participation in a MIPS APM.	CMS made no proposals under the IA Performance Category in the APM Scoring Standard and will continue to administer the same policy in 2018 (p. 478).
	Advancing Care Information (ACI) Performance Category. For CMS finalized a policy to attribute a single score to each MIPS eligible clinician in an APM Entity group by analyzing both individual and group TIN level data submitted for a MIPS eligible clinician and then use the highest available score. CMS previously finalized that it will assign a weigh of 0% to the ACI Performance Category in the final score for MIPS eligible clinicians in certain categories: • Hospital-based MIPS eligible clinicians • MIPS eligible clinicians facing a significant hardship • Certain types of non-physician practitioners (NPs, PAs, CRNAs, CNSs) (who are MIPS eligible clinicians). CMS proposes to include two additional groups of MIPS eligible clinicians to this policy: • ASC-based MIPS eligible clinicians; and	***CMS finalized its ACI Performance Category proposals under the APM Scoring Standard as proposed*** (p. 482).

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	• MIPS eligible clinicians who are using decertified EHR technology. Under the APM Scoring Standard, CMS proposes that if a MIPS eligible clinician who qualifies for 0% weighting of the ACI Performance Category is part of a TIN that includes one or more MIPS eligible clinicians who do not qualify for 0% weighting • CMS will not apply the 0% weighting to the qualifying MIPS eligible clinician; and • The TIN would still be required to report on behalf of the group; but • The TIN would not need to report data for the qualifying MIPS eligible clinician. CMS proposes that if a MIPS eligible clinician who qualifies for 0% weighting of the ACI Performance Category is part of a TIN that includes one or more MIPS eligible clinicians who do not qualify for 0% weighting CMS will not apply the 0% weighting to the qualifying MIPS eligible clinician; and the TIN would still be required to report on behalf of the group; but the TIN would not need to report data for the qualifying MIPS eligible clinician.	CMS noted that group level ACI reporting is not negatively affected by the failure of a single individual to report. This is because the group ACI score is based "only on average reported performance within the group, not the average reported performance of all eligible clinicians in the group – those who do not report are not factored into the denominator" (p. 481).
Calculating Total APM Entity Score	*Performance Category Weights*. CMS proposes the following APM Scoring Standard category weights for all APM Entities in Other MIPS APMs: • *Cost: 0%* • *Quality: 50%* • *IA: 20%* • *ACI 30%* If an APM Entity has its Quality Performance Category reweighted to 0%, CMS proposes to reweight the Improvement Activities Performance Category to 25% and ACI Performance Category to 75% If an APM Entity has the ACI Performance Category reweighted to 0%, CMS proposes to reweight the Quality Performance Category to 80% and the Improvement Activities Performance Category would remain at 20% *APM Scoring Standard Risk Factor Score*. CMS directs readers to the risk factor adjustment section of the MIPS Scoring Methodology described under "Complex Patient Bonus." APM Scoring Standard Small Practice	***CMS finalized its APM Scoring Standards weights as proposed*** (p. 484). CMS summarizes the APM Scoring Standard categories and weights in Table 12. ***CMS finalized its proposal*** (p. 487). ***CMS finalized its proposal*** (p. 487). CMS again referred readers to the general MIPS sections on the Complex Patient Bonus, Small Practice Bonus, and Final Scoring Methodology as it did not propose separate policies for those items under the APM Scoring

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	Bonus. CMS directs readers to the small practice adjustment section of the MIPS Scoring Methodology described under "Small Practice Bonus." APM Scoring Standard Final Score Methodology. CMS previous finalized a methodology for calculating a final score of 0-100 based on performance category scores. CMS directs readers to the "Final Score Calculation" section of the proposed rule for changes to this methodology.	Standard (p. 489).
MIPS APM Performance Feedback	CMS previously finalized that MIPS eligible clinicians scored under the APM Scoring Standard would receive feedback on the Quality Performance Category and Cost Performance Category (if applicable) based on data in the September 2016 Quality and Resource Use Report (Sept 2016 QRUR). Beginning in Performance Year 2018, CMS proposes that MIPS eligible clinicians with MIPS payment adjustments based on scores received under the APM Scoring Standard will receive performance feedback for the Quality Performance Category, ACI Performance Category, and Improvement Activities Category "to the extent data are available for the MIPS performance year." CMS proposes that in cases where performance data are not available for a MIPS APM performance category because the MIPS APM performance category has been weighted to 0% for that performance year, CMS would not provide performance feedback on that MIPS performance category.	***CMS finalized these policies as proposed*** (p. 491).
MIPS Final Score Methodology		
Introduction to MIPS Final Score Methodology and Policies Related to Improvement Scoring	For the quality performance category score, CMS proposes to measure improvement at the performance category level, since clinicians' choices on quality measures can change from year to year. For the cost performance category, CMS proposes to measure improvement at the measure level. CMS does not propose to score improvement in the improvement activities performance category or the ACI performance category at this time.	***CMS is finalizing its proposal. CMS will amend §414.1380(a)(1)(i) and §414.1380(a)(1)(ii) to add that improvement scoring is available for the quality performance category and the cost performance category beginning with the 2020 MIPS payment year. (p. 524)*** CMS intends to monitor and evaluate the implementation of improvement scoring for the quality and cost performance categories to determine how the policies established in this final rule are affecting MIPS eligible clinicians, including high-performing clinicians (p. 522). CMS also intends to develop additional educational materials to help explain improvement scoring (p. 523). CMS intends to implement improvement scoring in a transparent manner and will address any changes in improvement scoring through future rulemaking. (p. 522-523)
Scoring Flexibility for ICD-10 Measure Specification Changes	The quality and cost performance categories rely on measures that use detailed measure specifications that include ICD-10-CM/PCS ("ICD-10") code sets. CMS annually issues new ICD-10 coding updates, which are	***CMS is finalizing as proposed its policy to provide scoring flexibility for ICD-10 measure specification changes during the performance period. CMS is finalizing that it will establish an annual review process to***

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During the Performance Period	effective from October 1, through September 30. As part of this update, codes are added as well as removed from the ICD-10 code set. For measures considered significantly impacted by ICD-10 updates, CMS proposes to assess performance based only on the first 9 months of the 12-month performance period. Performance on measures that are not significantly impacted by changes to ICD-10 codes would continue to be assessed on the full 12-month performance period. CMS proposes an annual review process to analyze the measures that have a code impact. CMS also proposes to publish on the CMS website which measures are significantly impacted by ICD-10 coding changes and would require the 9-month assessment. CMS proposes to publish this information by October 1st of the performance period if technically feasible, but by no later than the beginning of the data submission period, which is January 1, 2019 for the 2018 performance period.	***analyze the measures that have a code impact and assess the subset of measures significantly impacted by ICD-10 coding changes during the performance period.*** Depending on the data available, CMS' determination as to whether a measure is significantly impacted by ICD-10 coding changes will include one or more the following factors: a more than 10 % change in codes in the measure numerator, denominator, exclusions, and exceptions; clinical guideline changes or new products or procedures reflected in ICD-10 code changes; and feedback on a measure received from measure developers and stewards. ***Beginning with the 2018 MIPS performance period, measures CMS determines to be significantly impacted by ICD-10 updates will be assessed based only on the first 9 months of the 12-month performance period. Lastly, CMS is finalizing as proposed that it will publish the list of measures requiring a 9-month assessment process on the CMS Website by October 1st of the performance period if technically feasible, but by no later than the beginning of the data submission period, which is January 2, 2019 for the 2018 MIPS performance period.*** CMS is codifying these policies for the quality performance category at §414.1380(b)(1)(xviii). (p. 532) ***CMS will apply a similar approach for measures in the cost performance category***, although CMS does not anticipate that the cost measures for the 2018 MIPS performance period (total per capita cost measure and the MSPB) would be significantly affected by ICD-10 changes. (p. 532) CMS also notes concern about instances where clinical guideline changes or other changes to a measure that occur during the performance period may significantly impact a measure and render the measure no longer comparable to the historical benchmark. As such, ***CMS seeks comment in this final rule with comment period regarding whether to apply similar scoring flexibility to such measures.*** (p. 533) Several commenters expressed concern that for certain measures, truncated reporting would not be appropriate due to their measure logic, and the measures would be negatively impacted by a shorter reporting window since it can take a full year to capture the data needed to successfully report these measures. (p. 529) One commenter expressed concern that, because certain standards used by registries to support measure reporting do not include timing information, such as the QRDA III standard, it is unclear how MIPS eligible clinicians would be able to submit only 9 months of data. This commenter urged CMS to, instead, adjust the value sets to account for the updates and have those changes

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		apply to the entire performance year, with no change to full-year measure submission, which CMS notes is not operationally feasible. Commenters also noted that the very short timeline between the discovery and announcement of the error and the end of the submission period would place an unreasonable burden on MIPS eligible clinicians to revise and revalidate their submissions. One commenter also noted that CMS's approach adds complexity because clinicians and groups would have to track which measures require a full year of reporting and which require only 9 months. (p. 530) CMS acknowledges these problems and notes that, where, it determines that scoring a significantly impacted measure based on only 9 months of data is inappropriate due to the measure logic or other factors, CMS will communicate with MIPS eligible clinicians and groups and interested parties and provide information to them through subregulatory guidance. However, CMS expects that these instances would be rare. (p. 530)
Scoring the Quality Performance Category for Data Submission via Claims, Data Submissions via EHR, Third Part Data Submission Options, CMS Web Interface, and Administrative Claims	CMS notes that, for the quality category, CMS is using updated terminology and proposes to update regulation text related to Quality category scoring. CMS reiterates, and proposes for inclusion in regulation text, its previously finalized policy that measure bonus points may be included in the calculation of the quality performance category percent score regardless of whether the measure is included in the calculation of the total measure achievement points, provided each measure is reported with sufficient case volume to meet the required case minimum, meet the required data completeness criteria, and not have a 0% performance rate.	***CMS is finalizing the proposed clarifications and redesignations in §414.1380(b)(1) related to measure achievement points and the quality performance category score.*** (p. 536) ***CMS is finalizing as proposed the amendments and technical corrections to §414.1380(b)(1) related to high priority measure bonus points.*** (p. 538)
	Quality Measure Benchmarks. CMS seeks feedback on whether to broaden the criteria for creating MIPS benchmarks to include PQRS and any data from MIPS, including voluntary reporters, that meet benchmark performance, case minimum and data completeness criteria when creating benchmarks. CMS does not propose any change to policies related to stratifying benchmarks by practice size for the 2020 MIPS payment year, but seeks comment on methods by which CMS could stratify benchmarks while maintaining reliability and stability of benchmarks to use in developing future rulemaking. Specifically, CMS seeks comment on methods for stratifying benchmarks by specialty or by place of service. CMS also requests comment on specific criteria to consider for stratifying measures, such as how to stratify submissions by	CMS thanks commenters for their responses to the solicitations but does not detail the nature of the comments. CMS notes that it will consider these comments in future rulemaking. (p. 539 and p. 540) CMS notes that it was guided by the principles used when developing the MIPS unified scoring system when developing the quality measure benchmarks. CMS sought a system that enables MIPS eligible clinicians, beneficiaries, and stakeholders to understand what is required for a strong performance in MIPS while being consistent with statutory requirements. CMS also wanted the methodology to be as a simple as possible while providing flexibility for the variety of practice types. Now that CMS has gone through 1 year of the program, CMS is asking for

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	multi-specialty practices or by practices that operate in multiple places of service.	comments on how to improve its quality measure benchmarking methodology. ***Specifically, CMS is requesting comments on whether the methodology has been successful in achieving its goals, and, if not, what other ways or approaches CMS could use that are in line with principles discussed above.*** (p. 540-541)
	Assigning Points Based on Achievement. CMS proposes to again apply a 3-point floor for each measure that can be reliably scored against a benchmark based on the baseline period, such that MIPS eligible clinicians would receive between 3 and 10 measure achievement points for each submitted measure that meets the case minimum and data completeness requirements for the 2018 MIPS performance period.	***CMS is finalizing the proposal to again apply the 3-point floor for quality measures that can be reliably scored against a baseline benchmark in the 2018 MIPS performance period.*** CMS will amend §414.1380(b)(1) accordingly. (p. 544) For clarification purposes, CMS also notes a statement in the proposed rule that said that measures without a benchmark based on the baseline period would be assigned between 3 and 10 measure achievement points for performance years after the first transition year. CMS clarifies that only measures without a benchmark based on the baseline period that later have a benchmark based on the performance period would be assigned between 3 and 10 measure achievement points for performance years after the first transition year. Measures without a benchmark based on the baseline or performance period would receive 3 points. (p. 543)
	CMS proposes not to score the "Health Status and Functional Status" SSM and the "Access to Specialists" SSM beginning with the 2018 MIPS performance period, but notes that continued data collection for the two SSMs is appropriate. Other than these two SSMs, CMS proposes to score the remaining 8 SSMs.	***CMS is finalizing the proposal to not score the "Health Status and Functional Status" and "Access to Specialists" SSMs beginning with the 2018 MIPS performance period, as proposed.*** (p. 547) CMS will continue to collect data on both the "Health Status and Functional Status" and "Access to Specialists" SSMs even though it will no longer score them. (p. 546)
	Identifying and Assigning Measure Achievement Points for Topped Out Measures. CMS proposes a method to phase in special scoring for topped out measure benchmarks starting with the 2018 MIPS performance period, provided that 2018 is the second consecutive year the measure benchmark is identified as topped out in the published benchmarks. CMS proposes to cap the score of topped out measures at 6 measure achievement points. CMS may also consider lowering the cap below 6 points in future years, especially if CMS removes the 3-point floor for performance in future years.	***CMS is finalizing with modifications the proposed policy to apply the special scoring cap to topped out measures. Specifically, CMS is finalizing a scoring cap of 7 points, rather than the proposed 6 points.*** CMS is finalizing a 7-point cap for multiple reasons, including simplicity, incentives to report non-topped out measures, and above median credit for performance. (p. 567) CMS believes the scoring cap would only be used for a few years because CMS anticipate that topped out measures generally will be removed after 3 years through rulemaking. (p. 567)
	CMS proposes not to apply the topped out measure cap to measures in the CMS Web Interface for the QPP. CMS also seeks comment on	***CMS is finalizing the proposed policy to not apply the topped-out measure cap to measures in the CMS Web Interface.*** CMS also

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	whether the proposed policy to cap the score of topped out measures should apply to SSMs in the CAHPS for MIPS survey measure or whether there is an alternative policy that could be applied for the survey measure due to high, unvarying performance within the SSM. CMS proposes applying the special topped out scoring to only 6 measures (see Table 18) for the 2018 performance period. Starting with the 2019 performance period, CMS proposes to apply the special topped out scoring method to all topped out measures, provided it is the second (or more) consecutive year the measure is identified as topped out.	appreciates the input and suggestions on the best way to proceed with topped out SSMs in the CAHPS for MIPS survey measures, and will take it into consideration in future rulemaking. (p. 568) ***CMS is finalizing its proposal to apply the special scoring policy to the 6 selected measures in Table 18 for the 2018 MIPS performance period and 2020 MIPS payment year. Finally, CMS is finalizing the proposed regulatory text changes with some modifications to reflect the other policies CMS is finalizing. (p. 567)*** - ***CMS is finalizing amendments to §414.1380(b)(1)(xiii)(A)*** to read that, for the 2020 MIPS payment year, the 6 measures identified in Table 18 will receive a maximum of 7 measure achievement points, provided that for the applicable submission mechanisms the measure benchmarks are identified as topped out again in the benchmarks published for the 2018 MIPS performance period. - ***CMS will also amend §414.1380(b)(1)(xiii)(B)*** to read that, beginning with the 2021 MIPS payment year, measure benchmarks, except for measures in the CMS Web Interface, that are identified as topped out for 2 or more consecutive years will receive a maximum of 7 measure achievement points in the second consecutive year it is identified as topped out, and beyond. CMS provides an illustration of the lifecycle for scoring and removing topped out measures on p. 569 and an example of applying the scoring cap in Table 19. ***CMS seeks comments on how to adjust the scoring policies and meet its policy goals and would welcome additional discussion on how this approach could be implemented in MIPS.*** (p. 559) CMS notes that there are multiple policies to mitigate the impact of its policies for topped out measures. For the 2018 MIPS performance period, CMS is only finalizing 6 topped out measures to which the scoring cap will apply. In the 2019 MIPS performance period, MIPS eligible clinicians will be able to submit quality data using more than one submission mechanism. Finally, CMS will consider the impact of the topped out measure lifecycle on certain clinicians in future rulemaking and refine policies if needed. (p. 561)

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		In response to comments to exempt QCDR measures from the scoring cap, CMS noted its belief that it is not necessary to delay implementation of scoring caps for QCDR submissions. CMS will monitor how the application of the scoring cap affects measure selection and propose any changes in future rulemaking. (p. 562) CMS also intends to work with developers using the Measure Development Plan as a strategic framework to add new measures into MIPS. CMS encourages stakeholders to develop and submit measures and composite measures for consideration. (p. 566)
	Case Minimum Requirements and Measure Reliability and Validity. CMS proposes to revise Class 2 measures to include only measures that cannot be scored based on performance because they do not have a benchmark or do not have at least 20 cases. Revised Class 2 measure would continue to receive 3 points. CMS also proposes to create Class 3 measures, which are measures that do not meet the data completeness requirement, in order to encourage complete reporting and to recognize that data completion is within the direct control of the MIPS eligible clinician. Proposed Class 3 measures would receive 1 point; however, if the measure is submitted by a small practice with 15 or fewer clinicians, the Class 3 measure would receive 3 points given concerns that data completeness may be harder to achieve for small practices with smaller case sizes.	***CMS is finalizing its proposal to maintain the policy to assign 3 points for measures that are submitted but do not meet the required case minimum or do not have a benchmark for the 2020 MIPS payment year.*** CMS will amend §414.1380(b)(1)(vii) accordingly. (p. 576) ***CMS is finalizing the policy to assign 1 point to measures that do not meet data completeness criteria, with an exception for measures submitted by small practices, which will receive 3 points.*** CMS will amend §414.1380(b)(1)(vii) accordingly. (p. 579)
	Scoring for MIPS Eligible Clinicians that Do Not Meet Quality Performance Category Criteria. CMS notes its previously finalized policy that if a MIPS eligible clinician submits any quality measures via EHR or QCDR, CMS would not conduct a validation process because CMS expects these MIPS eligible clinicians to have sufficient measures available to meet the requirements under the quality performance category. CMS is not proposing any changes to that policy. Rather, CMS proposes to validate the availability and applicability of measures only if a MIPS eligible clinician submits via claims submission options only, registry submission options only, or a combination of claims and registry submission options. In these cases, CMS proposes to apply the validation process to determine if other measures are available and applicable broadly across claims and registry submission options.	Given CMS' decision to allow reporting via multiple mechanisms beginning with year 3, ***CMS is finalizing its validation proposal with modification beginning with year 3 (CY 2019 performance period and 2021 MIPS payment year)***. ***For year 2 (CY 2018 performance period and 2020 MIPS payment year), CMS will continue to apply the year 1 validation process. CMS is modifying its validation proposal to provide that CMS will validate the availability and applicability of quality measures only with respect to the data submission mechanism(s) that a MIPS eligible clinician utilizes for the quality performance category for a performance period.*** (p. 586) CMS will not apply the validation process to any data submission mechanism that the MIPS eligible clinician does not utilize for the quality performance category for the performance period. Thus, MIPS eligible clinicians who submit quality data via claims only would be validated against claims measures only, and MIPS eligible

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		clinicians who submit quality data via registry only would be validated against registry measures only. MIPS eligible clinicians who, beginning with year 3, elect to submit quality data via claims and registry would be validated against both claims and registry measures; however, they would not be validated against measures submitted via other data submission mechanisms. (p. 584) CMS did not propose or finalize any changes to the policy that if a MIPS eligible clinician submits any quality measures via EHR or QCDR, CMS would not conduct a validation process. ***CMS seeks comment on how to modify the validation process for year 3 when it has multiple submission mechanisms.*** (p. 586) CMS reiterates that, in extremely rare instances, there may be a MIPS eligible clinician who may not have available and applicable quality measures; however, CMS believes this scenario should be extremely rare. If CMS is not able to score the quality performance category, CMS may reweight scores according to the reweighting policies. (p. 586)
	Incentives to Report High Priority Measures. CMS does not propose any changes regarding incentives to report high priority measures.	No changes proposed or finalized.
	Incentives to Use CEHRT to Support Quality Performance Category Submissions. CMS seeks comment on the use of health IT in quality measurement and how HHS can encourage the use of certified EHR technology in quality measurement as established in the statute. What other incentives within this category for reporting in an end-to-end manner could be leveraged to incentivize more clinicians to report electronically? What format should these incentives take? For example, should clinicians who report all of their quality performance category data in an end-to-end manner receive additional bonus points than those who report only partial electronic data? Are there other ways that HHS should incentivize providers to report electronic quality data beyond what is currently employed?	CMS thanks commenters for their responses to the solicitations but does not detail the nature of the comments. CMS notes that it will consider these comments in future rulemaking. (p. 588)
	Calculating Total Measure Achievement and Measure Bonus Points for Non-CMS Web Interface Reporters. CMS proposes, beginning with the 2018 MIPS performance period, a method to score quality measures if a MIPS eligible clinician submits measures via more than one of the following submission mechanisms: claims, qualified registry, EHR or QCDR submission options.	***CMS is finalizing its proposal to calculate the total measure achievement and bonus points when using multiple submission mechanisms proposals for year 3 to align with the multiple submission mechanisms policy which will be finalized for year 3.*** CMS will amend §414.1380(b)(1)(xii) accordingly. (p. 600)

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	CMS proposes to score measures across multiple mechanisms using the following rules: • CMS will only score measures within a single identifier. • If the MIPS eligible clinicians submit more than the required number of measures, they are scored on the required measures with the highest assigned measure achievement points. • CMS does not propose to aggregate measure results across different submitters to create a single score for an individual measure (for example, CMS will not aggregate scores from different TINs within a virtual group TIN to create a single virtual group score for the measures; rather, virtual groups must perform that aggregation across TINs prior to data submission to CMS). • CMS does not propose to combine CMS Web Interface measures or facility-based measurement with other group submission mechanisms (other than CAHPS for MIPS, which can be submitted in conjunction with the CMS Web Interface). • If a MIPS eligible clinician submits the same measure via 2 different submission mechanisms, CMS will score each mechanism by which the measure is submitted for achievement and take the highest measure achievement points of the 2 mechanisms. A MIPS eligible clinician can only be scored on one submission mechanism for a given measure. • Measure bonus points for high priority measures would be added for all measures submitted via all the different submission mechanisms available, even if more than 6 measures are submitted, but high priority measure bonus points are only available once for each unique measure. • Measure bonus points that are available for the use of end-to-end electronic reporting would be calculated for all submitted measures across all submission mechanisms, including measures that cannot be reliably scored against a benchmark. If the same measure is submitted through multiple submission mechanisms, then CMS would apply the bonus points only once to the measure.	
	Calculating Total Measure Achievement and Measure Bonus Points for CMS Web Interface Reporters. CMS proposes to continue to assign 3 points for measures with performance below the 30th percentile, provided the measure meets data completeness, has a benchmark, and	CMS did not specifically indicate a final decision on this policy in the preamble, but notes that it will reassess this policy again next year through rulemaking. (p. 601)

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	meets the case minimum requirements.	
	CMS did not propose any changes to previously finalized policy to exclude from scoring CMS Web Interface measures that are submitted but that do not meet the case minimum requirement or that lack a benchmark, or to the policy that measures that are not submitted and measures submitted below the data completeness requirements will receive a zero score.	No changes proposed or finalized.
	However, to further increase alignment with the Shared Savings Program, CMS proposes to also exclude CMS Web Interface measures from scoring if the measure is redesignated from pay for performance to pay for reporting for all Shared Savings Program ACOs (which may happen under certain circumstances) as long as the data completeness requirement is met, although CMS will recognize the measure was submitted.	***CMS is finalizing its proposal to not score CMS Web Interface measures redesignated as pay for reporting by the Shared Savings Program and to amend §414.1380(b)(1)(viii) accordingly. (p. 603)***
	Scoring Improvement for the MIPS Quality Performance Category Percent Score. CMS proposes to define an improvement percent score to mean the score that represents improvement for the purposes of calculating the quality performance category percent score. CMS also proposes that an improvement percent score would be assessed at the quality performance category level (versus individual measure level). CMS proposes to add the improvement percent score to an existing achievement percent score. Consistent with bonuses available in the quality performance category, CMS proposes that the improvement percent score may not total more than 10 percentage points. CMS invites public comments on these proposals.	***CMS is finalizing as proposed to define an improvement percent score to mean the score that represents improvement for the purposes of calculating the quality performance category score. CMS is also finalizing as proposed that an improvement percent score would be assessed at the quality performance category level and included in the calculation of the quality performance category percent score. CMS is also finalizing as proposed that the improvement percent score may not total more than 10 percentage points. (p. 613)***
	Data Sufficiency Standard: CMS proposes that, for the quality performance category, CMS would measure improvement when there is a comparable quality performance category achievement percent score for the MIPS performance period immediately prior to the current MIPS performance period. CMS also solicits comment on whether to require some level of year to year consistency when scoring improvement.	***CMS is finalizing as proposed that improvement scoring is available when the data sufficiency standard is met which means when data are available and a MIPS eligible clinician has a quality performance category achievement percent score for the previous performance period and the current performance period. (p. 621)***
	CMS proposes that "comparability" of quality performance category achievement percent scores would be determine if the quality performance category achievement percent score is available for the current performance period and the previous performance period, and that comparability would be established by looking first at the submitter	***CMS is also finalizing as proposed that data must be comparable to meet the requirement of data sufficiency, which means a quality performance category achievement percent score is available for the current and previous performance periods and quality performance category achievement percent scores can be compared. CMS is also***

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	of the data, as detailed below. • CMS proposes to compare results from an identifier when CMS receives submissions with that same identifier (either TIN/NPI for individual, or TIN for group, APM entity, or virtual group identifier) for two consecutive performance periods. • In circumstances where CMS does not have the same identifier for two consecutive performance periods, CMS proposes to identify a comparable score for individual submissions or calculate a comparable score for group, virtual group, and APM entity submissions. • For individual submissions, if CMS does not have a quality performance category achievement score for the same individual identifier in the immediately prior period, then CMS proposes to apply the hierarchy logic (described under "Final Score Used in Payment Adjustment Calculation") to identify the quality performance category achievement score associated with the final score that would be applied to the TIN/NPI for payment purposes. • For group submissions, when CMS does not have a comparable TIN group, virtual group, or APM Entity score, CMS proposes to calculate a score by taking the average of the individual quality performance category achievement scores for the MIPS eligible clinicians that were in the group for the current performance period. If CMS has more than one quality performance category achievement percent score for the same individual identifier in the immediately prior period, then CMS proposes to apply hierarchy logic (described under "Final Score Used in Payment Adjustment Calculation") to identify the quality performance category score associated with the final score that would be applied to the TIN/NPI for payment purposes. CMS would exclude any TIN/NPI's that did not have a final score because they were not eligible for MIPS. CMS would include quality performance category achievement percent scores of zero in the average. CMS details its proposals for the different cases when a group or individual would be eligible for improvement scoring under the proposal in Table 23.	***finalizing as proposed that the quality performance category achievement percent scores are comparable when submissions are received from the same identifier for two consecutive performance periods. CMS is also finalizing as proposed that if the identifier is not the same for 2 consecutive performance periods, then for individual submissions, the comparable quality performance category achievement percent score is the highest available quality performance category achievement percent score associated with the final score from the prior performance period that will be used for payment for the individual. For group, virtual group, and APM Entity submissions, the comparable quality performance category achievement percent score is the average of the quality performance category achievement percent score associated with the final score from the prior performance period that will be used for payment for each of the individuals in the group. (p. 622)***
	CMS is also proposing that MIPS eligible clinicians must fully participate in the current performance year to receive an improvement score. CMS	***CMS is finalizing as proposed that MIPS eligible clinicians must fully participate, which CMS proposes in §414.1380(b)(1)(xvi)(F) to mean***

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	proposes that the quality improvement percent score is zero if the clinician did not fully participate in the quality performance category for the current performance period.	***compliance with §414.1330 and §414.1340, in the current performance year. CMS is also finalizing as proposed that the quality improvement percent score is zero if the clinician did not fully participate in the quality performance category for the current performance period. (p. 627)***
	CMS proposes that if a MIPS eligible clinician has a previous year quality performance category score less than or equal to 30%, CMS would compare 2018 performance to an assumed 2017 quality performance category achievement percent score of 30%.	***CMS is also finalizing as proposed that if a MIPS eligible clinician has a previous year quality performance category score less than or equal to 30%, CMS would compare 2018 performance to an assumed 2017 quality performance category achievement percent score of 30%. (p. 627)***
	CMS proposes to focus on improvement based on achievement performance and would not consider measure bonus points in its improvement algorithm. Therefore, to measure improvement at the quality performance category level, CMS will use the quality performance category achievement percent score excluding measure bonus points and excluding any improvement score for the applicable years. This score is calculated using the following formula: *Quality performance category achievement percent score = total measure achievement points / total available measure achievement points*	***CMS is finalizing as proposed to state that improvement scoring is available to MIPS eligible clinicians that demonstrate improvement in performance in the current MIPS performance period compared to the performance in the previous MIPS performance period, based on measure achievement points. CMS is also finalizing as proposed to call the score at §414.1380(b)(1)(xvi)(D), which is based on achievement only, the "quality performance category achievement percent score," which is calculated using the formula as proposed and does not include bonus points or improvement adjustments. (p. 630)***
	CMS will compare the current MIPS performance period quality performance category achievement percent score to the previous score. If the current score is higher, the MIPS eligible clinician may qualify for an improvement percent score to be added into the quality performance category percent score for the current performance year. CMS provides the formula as follows: *Improvement percent score = (increase in quality performance category achievement percent score from prior performance period to current performance period / prior year quality performance category achievement percent score)*10%.* CMS also proposes that the improvement percent score cannot be negative (that is, lower than 0 percentage points). The improvement percent score would be zero for those who do not have sufficient data or who are not eligible under the proposal for improvement points. CMS is also proposing to cap the size of the improvement award at 10 percentage points, which CMS believes appropriately rewards improvement and does not outweigh percentage points available through achievement.	***CMS is finalizing as proposed to base the improvement percent score on the rate of increase in achievement methodology. CMS is finalizing as proposed that an improvement percent score cannot be negative (that is, lower than zero percentage points). CMS is also finalizing as proposed that improvement scoring is awarded based on the rate of increase in the quality performance category achievement percent score of individual MIPS eligible clinicians from the previous performance period to the current performance period. CMS is also finalizing as proposed that an improvement percent score is calculated by dividing the increase in the quality performance category achievement percent score of an individual MIPS eligible clinician or group from the prior performance period to the current performance period by the prior performance period's quality performance category achievement percent score, and multiplying by 10%. (p. 637)*** Policies regarding improvement scoring for the quality category are included in §414.1380(b)(1)(xvi).
	Calculating the Quality Performance Category Percent Score Including	***CMS is finalizing as proposed to incorporate the improvement percent***

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	Improvement. Under proposals in this rule, calculation for the proposed quality performance category percent score including improvement can be summarized in the following formula: *Quality performance category percent score = ([total measure achievement points + measure bonus points]/total available measure achievement points) + improvement percent score, not to exceed 100%.* This same formula and logic will be applied for both CMS Web Interface and Non-CMS Web Interface reporters.	***score, into the quality performance category percent score. CMS is also finalizing as proposed to add the improvement percent score to the quality performance score. CMS is also finalizing as proposed to clarify that the total possible points for the quality performance category cannot exceed 100 percentage points.*** CMS will update §414.1380(b)(1)(xvii) accordingly.[1] (p. 639)
Scoring the Cost Performance Category	CMS proposes to add improvement scoring to the cost performance category scoring methodology starting with the 2020 MIPS payment year, where improvement would be assessed at the measure level. CMS proposes a change in terminology to refer to the "cost performance category percent score" in order to be consistent with the terminology used in the quality performance category, such that the cost performance category score is the sum of the following, not to exceed 100%: the total number of achievement points earned by the MIPS eligible clinician divided by the total number of available achievement points; and the cost improvement score. CMS also proposes to add regulatory text to codify previous finalized policy to not calculate a cost performance category score under certain circumstances.	***CMS is finalizing its proposal to add improvement scoring to the cost performance category scoring methodology starting with the 2020 MIPS payment year. CMS is finalizing its proposal to change the terminology to refer to a cost performance category percent score. CMS is also finalizing the proposal to add regulatory text reflecting previously finalized policy not to calculate a cost performance category score if a MIPS eligible clinician or group is not attributed any cost measures because the MIPS eligible clinician or group has not met the case minimum requirements for any of the cost measures or a benchmark has not been created for any of the cost measures that would otherwise be attributed to the clinician or group.*** Regulatory changes are included at §414.1380(b)(2)(iii) and (v). (p. 643)
	Calculating Improvement at the Cost Measure Level. CMS proposes that improvement scoring is available to MIPS eligible clinicians and groups that demonstrate improvement in performance in the current MIPS performance period compared to their performance in the immediately preceding MIPS performance period, and that improvement will be measured at the measure level. CMS proposes a different data sufficiency standard for the cost performance category than for the quality performance category. First, for data sufficient to measure improvement to be available for the cost performance category, the same cost measure(s) would need to be specified for the cost performance category for 2 consecutive performance periods. Additionally, for a measure to be scored in either performance period, a MIPS eligible clinician would need to a have a sufficient number of attributed cases to meet or exceed the case minimum for the measure. Moreover, a clinician would have to report for MIPS using the same identifier (TIN/NPI combination for individuals, TIN	***CMS is finalizing all of its proposals related to measuring improvement in the cost performance category at the measure level. (p. 648)*** CMS notes that measures would not be eligible for improvement scoring in the first year they are adopted for MIPS as CMS would have no way of assessing how a clinician might have improved on a measure that was not previously included in the program. (p. 646)

[1] Note that the CFR citation is redesignated and was formerly §414.1380(b)(1)(xv).

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	for groups, or virtual group identifiers for virtual groups) and be scored on the same measure(s) for 2 consecutive performance periods. If the cost improvement score cannot be calculated because sufficient data is not available, CMS proposes to assign a cost improvement score of zero percentage points.	
	Improvement Scoring Methodology. CMS proposes to determine the cost improvement score in a manner similar to that used under the Shared Savings Program by subtracting the number of cost measures with significant declines from the number of cost measures with significant improvement, and then dividing the result by the number of cost measures for which the MIPS eligible clinician or group was scored in both performance periods, and then multiplying the result by the maximum cost improvement score for a year. CMS proposes that the cost improvement score could not be lower than zero, and therefore, could only be positive. CMS proposes to determine whether there was a significant improvement or decline in performance between the 2 performance periods by applying a common standard statistical test, a t-test, as is used in the Shared Savings Program. CMS proposes that although improvement would be measured according to the method described above, the maximum cost improvement score for the 2020 MIPS payment year would be zero percentage points given its proposal to weight the cost category at 0%. CMS proposes that if CMS maintain a weight of 10% for the cost performance category for the 2020 MIPS payment year, the maximum cost improvement score available in the cost performance category would be 1 percentage point out of 100 percentage points available for the cost performance category percent score.	***CMS is finalizing all of the proposals related to the improvement scoring methodology for the cost performance category, with the exception of the proposal to set the maximum cost improvement score at 0 percentage points for the 2020 MIPS payment year. Because CMS is finalizing the alternative option to weight the cost performance category at 10% of the final score for the 2020 MIPS payment year, CMS is adopting at §414.1380(b)(2)(iv)(E) its alternative of a maximum cost improvement score of 1 percentage point out of 100 percentage points available for the cost performance category. (p. 653)***
	Calculating the Cost Performance Category Percent Score with Achievement and Improvement. CMS proposes that a MIPS eligible clinician's cost performance category percent score is the sum of the following, not to exceed 100%: the total number of achievement points earned by the MIPS eligible clinician divided by the total number of available achievement points (which can be expressed as a percentage); and the cost improvement score. The formula would be *(Cost Achievement Points/Available Cost Achievement Points) + (Cost Improvement Score) = (Cost Performance Category Percent Score).*	***CMS is finalizing the method of calculating the cost performance category percent score as proposed. (p. 654)*** CMS provides an example of cost performance category percent scores along with the determination of improvement or decline in Table 25.
Facility-Based Measures Scoring	For the 2020 MIPS payment year and onward, CMS proposes to implement facility-based measures to add more flexibility for clinicians to	***CMS is finalizing the proposals on the general availability of facility-based measurement with the modification that facility-based***

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Option for the 2020 MIPS Payment Year for the Quality and Cost Performance Categories	be assessed in the context of the facilities at which they work. In CMS proposes that the quality and cost measures that may be used for facility-based measurement are those adopted under the value-based purchasing program of a specified facility program for the year specified. For the 2020 MIPS payment year, CMS proposes to include all the measures adopted for the FY 2019 Hospital Value-Based Purchasing (VBP) Program on the MIPS list of quality measures and cost measures. CMS will provide potential facility-based scores directly to clinicians to ensure that such clinicians are fully aware of the implications of their scoring elections under MIPS. CMS requests comment on whether this notification in advance of the conclusion of the MIPS performance period is appropriate, or if CMS should consider notifying facility-based clinicians later in the MIPS performance period or even after its conclusion. CMS proposes that the performance period for facility-based measurement is the performance period for the measures adopted under the value-based purchasing program of the facility of the year specified.	***measurement will not be available for clinicians until the 2019 MIPS performance period/2021 MIPS payment year. CMS is finalizing regulation text at §414.1380(e) that provides that for payment in the 2021 MIPS payment year and subsequent years, a MIPS eligible clinician or group may elect to be scored in the quality and cost performance categories using facility-based measures. (p. 665)*** ***CMS is finalizing the proposals at §414.1380(e)(6) that the quality and cost measures are those adopted under the value-based purchasing program of the facility program for the year specified and that the performance period for facility-based measurement is the performance period for the measures adopted under the value-based purchasing program of the facility of the year specified. (p. 665)*** CMS notes that these provisions refer to the general parameters of its method of facility-based measurement, but not specific programs and years. (p. 692) CMS notes its concern that CMS might not have the operational ability to inform clinicians soon enough during the MIPS performance period in 2018 for them to know that they could select facility-based measurement as opposed to another method. CMS also notes its belief that the comments reflect some lack of understanding of how elements of the policy might apply to clinicians that may qualify for facility-based measurement. CMS plans to use this additional year for outreach and, if technically feasible, informing clinicians if they would have met the requirements for facility-based measurement based on the finalized policy and what their scoring might have been based on an attributed hospital. CMS believes this additional year of outreach will best prepare clinicians to make decisions about participating in facility-based measurement. (p. 665) CMS will also investigate whether it would be technically feasible and appropriate to distribute information to attributed facilities about the clinicians that could elect attribution of facility performance measures for purposes of the MIPS program. (p. 663) ***CMS is finalizing that clinicians practicing in the inpatient hospital will be eligible for facility-based measurement beginning with the 2019 MIPS performance period and 2021 MIPS payment year.*** However, in the future CMS will consider opportunities to expand the program to other facilities, based on the status of the facility value-based purchasing program, the applicability of measures, and the ability to appropriately attribute a clinician to a facility. Any new settings for facility-based measurement would be proposed in future rulemaking. (p. 661)

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		In response to questions about applying facility-based measurement to the ACI and IA categories, CMS states that it did not propose that those scored under facility-based measurement would have different requirements for the ACI or IA performance categories. Clinicians or groups would still be scored based on their own performance (not a facility's performance) on those performance categories unless other exclusions apply. In addition, CMS notes that section 1848(q)(2)(C)(ii) of the Act states that CMS may use measures used for a payment system other than that used for physicians for the purposes of the quality and cost performance categories, but does not address the advancing care information and improvement activities performance categories. (p. 663)
	Facility-Based Measurement Applicability. CMS proposes that a MIPS eligible clinician is eligible for facility-based measurement under MIPS if they are determined facility-based as an individual. CMS proposes that a MIPS eligible clinician is considered facility-based as an individual if the MIPS eligible clinician furnishes 75% or more of their covered professional services in sites of service identified by the POS codes used in the HIPAA standard transaction as an inpatient hospital, as identified by POS code 21, or an emergency room, as identified by POS code 23, based on claims for a period prior to the performance period as specified by CMS, pending technical feasibility. CMS seeks comments on whether POS 22 should be included in determining if a clinician is facility-based and how CMS might distinguish those clinicians who contribute to inpatient care from those who do not. Clinicians would be determined to be facility-based through an evaluation of covered professional services between September 1 of the calendar year 2 years preceding the performance period through August 31 of the calendar year preceding the performance period with a 30-day claims run out.	***CMS is finalizing the proposals codified at §414.1380(e)(2) for the determination of eligibility for facility-based measurement as an individual.*** CMS notes that facility-based measurement will not be available until the 2019 MIPS performance period/2021 MIPS payment year so clinicians will not be eligible until that time. CMS understands that there are concerns that some clinicians who practice primarily or exclusively in hospitals will not be eligible for facility-based measurement, particularly due to the complicating factor of observation services. CMS will use the next year to further examine this issue and determine if changes in eligibility should be proposed in future rulemaking. (p. 673) With respect to CMS' solicitation on whether to include POS 22 for on-campus outpatient hospital in the determination of facility-based status, CMS remains concerned that including codes for outpatient hospital services could make eligible for facility-based measurement clinicians who have little or no contribution to a hospital's performance in the Hospital VBP Program. CMS recognizes that observation services are similar to services provided in the inpatient hospital setting in many cases. However, there are many services, such as outpatient clinic visits, which include patients who may never visit the hospital in question as inpatients. CMS notes its intent to further study the impact of including outpatient services on eligibility for facility-based clinicians and to determine if there is another method to distinguish observation services from other outpatient services. Given the one-year delay in implementation of facility-based measurement, CMS will have additional time for analysis and outreach to clinicians. CMS hopes that this outreach will help to inform clinicians about the applicability of facility-based measurement. CMS will make future changes to the applicability of

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		facility-based measurement in the context of that outreach and additional analysis. Any changes would be proposed in future rulemaking. ***CMS is specifically seeking comments on ways to identify clinicians who have a significant presence within the inpatient setting and address the concerns that CMS noted above.*** (p. 671-672)
	CMS is also proposing that a MIPS eligible clinician is eligible for facility-based measurement under MIPS if they are determined facility-based as part of a group. CMS proposes that a facility-based group is a group in which 75% or more of the MIPS eligible clinician NPIs billing under the group's TIN are eligible for facility-based measurement as individuals. CMS requests comments on this proposal and alternative proposal.	***CMS is finalizing its proposal for determining which groups are facility-based in regulation text at §414.1380(e)(2)(ii). (p. 678)*** In 2018, CMS will provide more information to clinicians and groups on their eligibility for facility-based measurement and hopes that sharing this information will help to provide more clarity. CMS will revisit this standard for identifying when a clinician group is a facility-based group eligible for facility-based measurement in future rulemaking if changes are needed. (p. 675) CMS notes that facility-based measurement will not be available until the 2019 MIPS performance period/2021 MIPS payment year so a facility-based group will not exist before that time. (p. 678)
	Facility Attribution for Facility-Based Measurement. CMS proposes that MIPS eligible clinicians who elect facility-based measurement would receive scores derived from the value-based purchasing score for the facility at which they provided services for the most Medicare beneficiaries during the period of September 1 of the calendar year 2 years preceding the performance period through August 31 of the calendar year preceding the performance period with a 30 day claims run out.	***CMS is finalizing its proposal.*** CMS notes that facility-based measurement will not be available until the 2019 MIPS performance period/2021 MIPS payment year so clinicians will not be assigned to a facility for attribution of the facility's performance before that time. (p. 682) CMS did not specifically address the issue of how facility-based groups would be assigned to a facility for purposes of attributing facility performance to the group, so CMS plans to address this issue in the next QPP rulemaking cycle. (p. 681)
	Election of Facility-Based Measurement. CMS proposes that individual MIPS eligible clinicians or groups who wish to have their quality and cost performance category scores determined based on a facility's performance must elect to do so by submitting their election during the data submission period through the attestation submission mechanism established for the improvement activities and advancing care information performance categories.	***CMS is not finalizing a policy for how an individual clinician or group will elect to use and be identified as using facility-based measurement for the MIPS program***, which is not necessary this year due to the one-year delay. CMS will use the additional time to examine the attestation process it proposed and the alternative opt-out process. CMS intends to work with stakeholders to identify a procedure that best balances administrative burden and clinician choice for proposal in next year's proposed rule. (p. 685) In light of CMS' interest in reducing burden, CMS does prefer an option that would not require a clinician or practice to notify CMS through attestation or other method. ***CMS therefore seeks comment on whether a process by which a clinician or group would be automatically assigned a score under facility-based measurement but be notified and given the opportunity to opt out of facility-based measurement would be***

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		appropriate. (p. 685)
	Facility-Based Measures. CMS proposes that facility-based individual MIPS eligible clinicians or groups that are attributed to a hospital would be scored on all the measures on which the hospital is scored for the Hospital VBP Program via the Hospital VBP Program's Total Performance Score (TPS) scoring methodology.	***CMS is not finalizing its proposals regarding selection of measures for facility-based measurement for the 2018 MIPS performance year because CMS is not implementing facility-based measurement for that year and as such cannot finalize any measures or scoring for facility-based measurement. (p. 692-693)*** *However, CMS believes that the policy approach of using all measures from a value-based purchasing program is appropriate. CMS intends to propose measures that would be available for facility-based measurement for the 2019 MIPS performance period in future rulemaking. (p. 693)*
	CMS proposes that there are no data submission requirements for the facility-based measures used to assess performance in the quality and cost performance categories, other than electing the option through attestation.	***CMS is finalizing this proposal at §414.1380(e)(4) with a modification to delete the reference to electing the option through attestation and to make other clarifying edits (p. 692).***
	Scoring Facility-Based Measurement. To apply the Hospital VBP Program scoring to MIPS, CMS proposes that facility-based scoring is available for the quality and cost performance categories, and that those who meet facility-based eligibility requirements and who elect facility-based measurement will be scored under the facility-based measurement scoring standard under MIPS.	***CMS is finalizing this proposal with modification to regulation text at §414.1380(e) to accommodate the delay in implementation of facility-based measurement and to remove specific references to the use of the FY 2019 Hospital VBP.*** CMS will address this issue in future rulemaking to identify the specifics of the Hospital VBP Program performance and scoring to be used for facility-based measurement. (p. 694)
	CMS proposes that the benchmarks for facility-based measurement are those that are adopted under the value-based purchasing program of the facility for the year specified.	***CMS is finalizing this policy as proposed.*** While under this policy CMS would routinely use benchmarks associated with specified value-based purchasing programs, CMS also specifies that it will identify the particular value-based purchasing program in future rulemaking. (p. 695)
	For the quality and cost performance categories, CMS proposes that the score for facility-based measurement is reached by determining the percentile performance of the facility determined in the value-based purchasing program for the specified year and awarding a score associated with that same percentile performance in the MIPS quality performance category score for those clinicians who are not scored using facility-based measurement.	***CMS is finalizing this proposal with modifications to regulatory text at §414.1380(e) to clarify the applicable year for the value-based purchasing program performance. (p. 698)***
	CMS does not propose any additional improvement scoring for facility-based measurement for either the quality or cost performance category since improvement is already captured in the scoring method used by the Hospital VBP Program.	***CMS is finalizing this policy as proposed. (p. 701)***

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	CMS does not propose to calculate additional high priority bonus points for facility-based measurement. CMS does not propose to calculate additional end-to-end electronic reporting bonus points for facility-based measurement. CMS welcomes public comments on this approach.	***CMS is finalizing this policy as proposed. (p. 702)***
	Special rules for Facility-based Measurement. CMS would be unable to calculate a facility-based score based on the hospital's performance, and facility-based clinicians would generally be required to participate in MIPS via another method. However, CMS proposes that MIPS eligible clinicians who are facility-based and affected by extreme and uncontrollable circumstances, such as natural disasters, may apply for reweighting.	***CMS is finalizing all proposals for special rules. (p. 707-708)***
	In the event that a hospital obtains a successful correction or appeal of its Total Performance Score, CMS would update MIPS eligible clinicians' quality and cost performance category scores accordingly, as long as the update could be made prior to the application of the MIPS payment adjustment for the relevant MIPS payment year.	***CMS is finalizing this policy as proposed. (p. 707)***
	CMS also proposes to adopt a floor on the Hospital VBP Program Total Performance Score for purposes of facility-based measurement under MIPS so that any score in the quality performance category, once translated into the percentile distribution described above, that would result in a score of below 30% would be reset to a score of 30% in the quality performance category. CMS does not propose any floor for the cost performance category for facility-based measurement. CMS also proposes that MIPS eligible clinicians who elect facility-based measurement would not be scored on other cost measures specified for the cost performance category. CMS proposes to use the higher of the two scores for the quality performance category and base the score of the cost performance category on the same method (that is, if the facility-based quality performance category score is higher, facility-based measurement is used for quality and cost).	***CMS is finalizing these policies as proposed. (p. 707)*** In response to opposition to the proposal to adopt a floor, CMS states that it continues to believe that this policy is consistent with the score that might be received for a clinician who submitted data that meet data completeness on six measures through another mechanism, and CMS does not believe it would be appropriate to allow a clinician to receive a lower score based on the selection of this measurement option. CMS will continue to evaluate this floor in the context of scoring policies that are established in the quality performance category for other methods of participating in MIPS. CMS also notes that this option is not being finalized for the 2018 MIPS performance period, so concerns raised about the minimum score under this proposal being higher than the performance threshold for the 2018 MIPS performance period is no longer relevant at this time. CMS will consider comments on this topic in future rulemaking. (p. 707)
Scoring the Improvement Activities Performance Category	Beginning with the 2018 MIPS performance period, CMS proposes to no longer require self-identification for a non-patient facing MIPS eligible clinician, a small practice, a practice located in a rural area, or a practice in a geographic HPSA or any combination thereof. CMS proposes this	***CMS is finalizing its proposal, as proposed, to no longer require these self-identifications for non-patient facing MIPS eligible clinicians, small practices, practices located in rural areas or geographic HPSAs, or any combination thereof, beginning with the 2018 MIPS performance period***

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	change because it is technically feasible to identify these MIPS eligible clinicians during the IA attestation. However, MIPS eligible clinicians that are part of a certified patient-centered medical home or comparable specialty practice are still required to self-identify for the 2018 MIPS performance period, and CMS will validate these self-identifications as appropriate.	***and for future years. (p. 717)***
Scoring the Advancing Care Information (ACI) Performance Category	CMS refers readers to CMS' discussion of scoring for the ACI performance category.	CMS refers readers to CMS' discussion of scoring for the ACI performance category.
Calculating the Final Score	*Considerations for Social Risk.* CMS continues to seek public comment on whether CMS should account for social risk factors in the MIPS, and if so, what method or combination of methods would be most appropriate for accounting for social risk factors in the MIPS. CMS is seeking comments on whether any of these methods should be considered, and if so, which of these methods or combination of methods would best account for social risk factors in MIPS, if any. In addition, CMS is seeking public comment on which social risk factors might be most appropriate for stratifying measure scores and/or potential risk adjustment of a particular measure. CMS is seeking comment on which of these factors, including current data sources where this information would be available, could be used alone or in combination, and whether other data should be collected to better capture the effects of social risk. CMS also welcomes comment on operational considerations.	CMS notes that it is concerned about holding providers to different standards for the outcomes of their patients with social risk factors, because CMS does not want to mask potential disparities. CMS believes that the path forward should incentivize improvements in health outcomes for disadvantaged populations while ensuring that beneficiaries have adequate access to excellent care. CMS thanks commenters for this important feedback and will continue to consider options to account for social risk factors that would allow CMS to view disparities and potentially incentivize improvement in care for patients and beneficiaries. CMS will consider the comments received in preparation for future rulemaking. (p. 722)
	Complex Patient Bonus. CMS proposes a complex patient bonus for the 2018 MIPS performance period (2020 MIPS payment year). For the 2020 MIPS payment year, CMS proposes to base the complex patient bonus on the average HCC risk score. CMS proposes to calculate an average HCC risk score, using the model adopted for Medicare Advantage risk adjustment purposes, for each MIPS eligible clinician or group, and to use that average HCC risk score as the complex patient bonus. CMS would add this amount (the size of the average HCC risk score) to the final score for the 2020 MIPS payment year for MIPS eligible clinicians that submit data (as explained below) for at least one performance category. CMS proposes that if a calculation results in greater than 100 points, then the final score would be capped at 100 points. CMS proposes that the complex patient bonus cannot exceed 3 points. Finally, CMS proposes that the MIPS eligible clinician, group, virtual group or APM Entity must submit data on at least one measure or	***CMS is finalizing a modified complex patient bonus which will be added to the final score for the 2020 MIPS payment year that includes the sum of the average HCC risk scores and proportion of dual eligible beneficiaries (multiplied by 5 points), subject to a 5-point cap. This reflects the use of both CMS' proposed and alternative policies for the complex patient bonus. CMS will calculate the average HCC risk score and dual eligible ratio as described in the proposed rule.*** CMS will update regulation text at §414.1380(c)(3). (p. 739) CMS provides a rationale for increasing the bonus from 3 to 5 points on p. 730. In response to requests to extend the complex patient bonus into future years, CMS notes that it intends this complex patient bonus as a short-term solution to account for risk factors in MIPS as CMS continues to evaluate ongoing research into this area as well as review available data to support various approaches to accounting for risk factors. CMS plans to review results of implementation of this complex patient bonus in the

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	activity in a performance category during the performance period to receive the complex patient bonus. CMS would calculate the average HCC risk score for a MIPS eligible clinician or group by averaging HCC risk scores for beneficiaries cared for by the MIPS eligible clinician or clinicians in the group for the second 12-month segment of the low-volume/non-patient-facing eligibility period, which spans from the last 4 months of a calendar year 1 year prior to the performance period followed by the first 8 months of the performance period in the next calendar year (September 1, 2017 to August 31, 2018 for the 2018 MIPS performance period). For MIPS APMs and virtual groups, CMS proposes to use the beneficiary weighted average HCC risk score for all MIPS eligible clinicians, and if technically feasible, TINs for models and virtual groups which rely on complete TIN participation, within the APM Entity or virtual group, respectively, as the complex patient bonus. CMS would calculate the weighted average by taking the sum of the individual clinician's (or TIN's as appropriate) average HCC risk score multiplied by the number of unique beneficiaries cared for by the clinician and then divide by the sum of the beneficiaries cared for by each individual clinician (or TIN as appropriate) in the APM Entity or virtual group. For the 2018 MIPS performance period, the HCC risk scores would be calculated based on beneficiary services from the 2017 calendar year, similar to how CMS uses prior year diagnoses to set Medicare Advantage rates. This approach mitigates the risk of "upcoding" to get higher expected costs, which could happen if concurrent risk adjustments were incorporated. CMS also seeks comment on an alternative complex patient bonus methodology that would likewise be applied to the 2020 MIPS payment year only. Under the alternative, CMS would apply a complex patient bonus based on a ratio of patients who are dual eligible, because CMS believes that dual eligible status is a common indicator of social risk for which CMS currently has data available. CMS would calculate a dual eligible ratio for each MIPS eligible clinician based on the proportion of unique patients who have dual eligible status (including both full and partial Medicaid beneficiaries, as identified at the conclusion of the same 12-month period identified for the HCC-based bonus from the state Medicare Modernization Act files) seen by the MIPS eligible clinician among all unique patients seen during the same 12-month period identified for the proposed HCC-based bonus. For MIPS APMs and virtual groups, CMS would use the average dual eligible patient ratio for all MIPS	2020 MIPS payment year, as well as available reports, and as appropriate, update its approach to accounting for social risk factors. (p. 733) CMS notes that all MIPS eligible clinicians would receive a complex patient bonus as long as they submit data on at least one measure or activity in a performance category and that its updated analysis estimates that the median complex patient bonus would be 2.97 points. (p. 738) Table 27 includes the distribution for the complex patient bonus under the final policy.

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	eligible clinicians, and if technically feasible, TINs for models and virtual groups which rely on complete TIN participation, within the APM entity or virtual group, respectively. CMS would propose to multiply the dual eligible ratio by 5 points to calculate a complex patient bonus for each MIPS eligible clinician. For example, a MIPS eligible clinician who sees 400 patients with dual eligible status out of 1000 total Medicare patients seen during the second 12-month segment of the eligibility period would have a complex patient ratio of 0.4, which would be multiplied by 5 points for a complex patient bonus of 2 points toward the final score. An individual would be counted as a full-benefit or partial-benefit dual patient if the beneficiary was identified as a full-benefit or partial-benefit dual in the state MMA files at the conclusion of the second 12-month segment of the eligibility determination period.	
	Small Practice Bonus for the 2020 MIPS Payment Year. CMS proposes an adjustment to the final score for MIPS eligible clinicians in small practices (referred to herein as the "small practice bonus"). CMS proposes the bonus only for the 2018 MIPS performance period (2020 MIPS payment year) and will assess on an annual basis whether to continue the bonus and how the bonus should be structured. To receive the small practice bonus, CMS proposes that the MIPS eligible clinician must participate in the program by submitting data on at least one performance category in the 2018 MIPS performance period. CMS proposes to add this small practice bonus of 5 points to the final score for those clinicians and groups who meet the definition of a small practice and participate in the program.	***CMS is finalizing its proposal at §414.1380(c)(4) to add a small practice bonus of 5 points to the final score for MIPS eligible clinicians, groups, APM Entities, and virtual groups that meet the definition of a small practice (as revised) and submit data on at least one performance category in the 2018 performance period.*** (p. 748) In response to requests to extend the small practice bonus to future years, CMS notes that it is finalizing the small practice bonus for the 2020 MIPS payment year only. CMS intends to continue to evaluate options to address challenges small practices face in future rulemaking, including continuation of the small practice bonus, as appropriate. (p. 745) In response to comments requesting a similar bonus for rural practices, CMS notes that it does not believe a bonus for such a bonus is appropriate at this time. (p. 748)
	Final Score Calculation. CMS proposes to calculate the final score for all MIPS eligible clinicians, groups, virtual groups, and MIPS APMs, starting with the 2020 MIPS payment year, using the formula below (as specified at §414.1380(c)) and to update the definition of "Final Score" at §414.1305. *Final score = [(quality performance category percent score x quality performance category weight) + (cost performance category percent score x cost performance category weight) + (improvement activities performance category score x improvement activities performance category weight) + (advancing care information performance category score x*	***CMS is finalizing this policy as proposed (p. 751)***

advancing care information performance category weight)] x 100 + [the complex patient bonus + the small practice bonus], not to exceed 100 points.

CMS also proposes that a MIPS eligible clinician with fewer than 2 performance category scores would receive a final score equal to the performance threshold.

General Weights. Based on proposals for weighting the quality and cost performance categories included in this rule and discussed above, finalized and proposed weights for each performance category are included in the table below.

Performance Category	Transition Year	2018 MIPS Performance Year	2019 MIPS Performance Year and Beyond
Quality	60%	60%	30%
Cost	0%	0%	30%
Improvement Activities	15%	15%	15%
Advancing Care Information	25%	25%	25%

CMS is finalizing a weight of 10% for the cost performance category for the 2020 MIPS payment year, with a corresponding weight of 50% for the quality performance category (p. 752) Table 28 and the table below, summarize the weights for each performance category.

Performance Category	Transition Year	2018 MIPS Performance Year	2019 MIPS Performance Year and Beyond
Quality	60%	50%	30%
Cost	0%	10%	30%
Improvement Activities	15%	15%	15%
Advancing Care Information	25%	25%	25%

Flexibility for Weighting Performance Categories. For the 2020 MIPS payment year, CMS proposes to determine if there are sufficient measures applicable and available for a category as follows, and assign a scoring weight of 0% to a performance category and redistribute its weight to the other performance categories in the following scenarios.

CMS proposes that having sufficient measures applicable and available means that CMS can calculate a quality performance category percent score for the MIPS eligible clinician because at least one quality measure is applicable and available to the MIPS eligible clinician.

For the cost performance category, CMS continues to apply its policy that if a MIPS eligible clinician is not attributed a sufficient number of cases for a measure, or if a measure does not have a benchmark, then the

CMS is finalizing these policies as proposed. (p. 756)

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	measure will not be scored for that clinician. In the event CMS does not finalize the proposal to set the weight of the cost performance category to 0%, CMS proposes to redistribute the weight of the cost performance category if the clinician does not receive a cost performance category percent score. For the improvement activities performance category, while CMS believes that all MIPS eligible clinicians will have sufficient activities applicable and available, CMS proposes a policy for reweighting under extreme and uncontrollable circumstances.	
	Extreme and Uncontrollable Circumstances. For these performance categories, CMS proposes to define "extreme and uncontrollable circumstances" as rare (that is, highly unlikely to occur in a given year) events entirely outside the control of the clinician and of the facility in which the clinician practices that cause the MIPS eligible clinician to not be able to collect information that the clinician would submit for a performance category or to submit information that would be used to score a performance category for an extended period of time CMS proposes to review both the circumstances and the timing independently to assess the availability and applicability of measures and activities for each performance category. Beginning with the 2020 MIPS payment year, CMS proposes that CMS would reweight the quality, cost, and/or improvement activities performance categories if a MIPS eligible clinician, group, or virtual group's request for a reweighting assessment based on extreme and uncontrollable circumstances is granted. CMS proposes that MIPS eligible clinicians could request a reweighting assessment if they believe extreme and uncontrollable circumstances affect the availability and applicability of measures for the quality, cost, and improvement activities performance categories. To the extent possible, CMS would seek to align the requirements for submitting a reweighting assessment for extreme and uncontrollable circumstances with the requirements for requesting a significant hardship exception for the ACI performance category. For example, CMS proposes to adopt the same deadline (December 31, 2018 for the 2018 MIPS performance period) for submission of a reweighting assessment (see ACI section of rule), and CMS would encourage the requests to be submitted on a rolling basis. CMS proposes the reweighting assessment must include the nature of the extreme and	***CMS is finalizing the proposed policies for Extreme and Uncontrollable Circumstances as proposed, with one exception; CMS is not finalizing that a virtual group submitting reweighting application must have a majority of its TINs impacted by extreme and uncontrollable circumstances in order for the virtual group to qualify for reweighting, but instead will review each virtual group application on a case-by-case basis. CMS will specify the form and manner in which the reweighting application must be submitted outside the rulemaking process. CMS invites public comment on alternatives to its policies, such as using a shortened performance period, which may allow CMS to measure performance, rather than reweighting the performance categories to 0%.*** (p. 764) In responses to comments to include additional types of events in the definition of extreme and uncontrollable events, e.g. events caused by third-party intermediaries; physician illness; and maternity leave, CMS notes that it continues to believe it is appropriate to maintain a narrow definition. For third-party intermediaries, CMS believes it is more appropriate to monitor third-party issues and take additional action if needed in the future. For those affected by illness or on maternity leave, MCS will review each application on a case-by-case basis and determine whether reweighting is warranted based on the information provided. (p. 763) CMS notes that these policies for reweighting the quality, cost, and improvement activities performance categories based on extreme and uncontrollable circumstances will apply beginning with the 2018 MIPS performance period/2020 MIPS payment year. CMS recognizes, however, that MIPS eligible clinicians have been affected by the recent hurricanes Harvey, Irma, and Maria, which affected large regions of the United

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	uncontrollable circumstance, including the type of event, date of the event, and length of time over which the event took place, performance categories impacted, and other pertinent details that impacted the ability to report on measures or activities to be considered for reweighting of the quality, cost, or improvement activities performance categories (for example, information detailing how exactly the event impacted availability and applicability of measures). If CMS finalizes this the policy to allow reweighting based on extreme and uncontrollable circumstances beginning with the 2020 MIPS payment year, CMS would specify the form and manner in which these reweighting applications must be submitted outside of the rulemaking process after the final rule is published. CMS proposes to use this policy for measures which CMS derives from claims data to exempt a MIPS eligible clinician from all quality and cost measures calculated from administrative claims data if the clinician is granted an exception for the respective performance categories based on extreme and uncontrollable circumstances. This policy would not include issues that third party intermediaries, such as EHRs, Qualified Registries, or QCDRs, might have submitting information to MIPS on behalf of a MIPS eligible clinician. For virtual groups, CMS proposes to ask the virtual group to submit a reweighting assessment for extreme and uncontrollable circumstances similar to groups, and CMS would evaluate whether sufficient measures and activities are applicable and available to the majority of TINs in the virtual group. CMS proposes that a majority of TINs in the virtual group would need to be impacted before CMS grant an exception. CMS proposes that the reweighting assessment due to extreme and uncontrollable circumstances for the quality, cost, and improvement activities would not be available to APM Entities in the APM scoring standard.	States in August and September of 2017. CMS is adopting interim final policies for the 2017 performance period/2019 MIPS payment year for MIPS eligible clinicians who have been affected by these hurricanes and other natural disasters and refers readers to the interim final rule with comment period. (p. 765)

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	Redistributing Performance Category Weights. CMS proposes redistributions for the 2020 MIPS payment year, assuming CMS' proposal to weight the cost performance category at 0% are finalized. These proposals are detailed in Table 38 of the proposed rule. CMS proposes redistribution of performance category weights for the 2020 MIPS payment year under the scenario that CMS does not finalize its proposal to weight the cost performance category at 0%. CMS proposes to not redistribute the weight of any other performance categories to the cost performance category. • If a MIPS eligible clinician qualifies for reweighting of the quality performance category and the ACI performance category, then CMS would redistribute the weight of both categories to the improvement activities performance category and would not redistribute the weight to the cost performance category. • If a MIPS eligible clinician does not receive a cost performance category percent score, CMS proposes to redistribute the weight of the cost performance category to the quality performance category. ○ If a MIPS eligible clinician does not receive a quality performance category percent score or a cost performance category percent score, CMS proposes to redistribute the weight of the cost performance category equally to the remaining performance categories that are not reweighted. • If the quality performance category is reweighted to zero, but the cost category weight is not 0%, AND either the improvement activities or ACI performance category is reweighted to 0%, then CMS would redistribute the weight of the quality performance category to the remaining performance category that is not weighted at 0%. CMS would not redistribute the weight to the cost performance category.	***CMS is finalizing its proposals for redistributing the performance category weights for the 2020 MIPS payment year, with the exception of the proposals that assume the cost performance category will be weighted at 0% in the final score as proposed,*** given that CMS finalized that the cost performance category weight for the 2018 MIPS performance period and the 2020 MIPS payment period is 10%. (p. 772) Table 29 and the table below summarize the final reweighting policies for the 2018 MIPS performance period and 2020 MIPS payment year. **Reweighting Scenario / Quality / Cost / IA / ACI** **No reweighting needed** - Scores for all categories: 50% / 10% / 15% / 25% **Reweight 1 category** - No Cost: 60 / 0 / 15 / 25 - No ACI: 75 / 10 / 15 / 0 - No Quality: 0 / 10 / 45 / 45 - No IA: 65 / 10 / 0 / 25 **Reweight 2 categories** - No cost and no ACI: 85 / 0 / 15 / 0 - No cost and no Quality: 0 / 0 / 50 / 50 - No cost and no IA: 75 / 0 / 0 / 25 - No ACI and no Quality: 0 / 10 / 90 / 0 - No ACI and no IA: 90 / 10 / 0 / 0 - No Quality and no IA: 0 / 10 / 0 / 90

MIPS Payment Adjustments

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Payment Adjustment Identifier and Final Score Used in Payment Adjustment Calculation	CMS does not propose any changes to its policy to use a single identifier, TIN/NPI, for all MIPS eligible clinicians, regardless of whether the TIN/NPI was measured as an individual, group, or APM Entity group. CMS clarifies that the following final policies apply beginning with the	***CMS is finalizing these policies as proposed. (p. 777).*** Table 30 and Table 31 illustrate the final policies for determining which final score will be used when more than one final score is associated with a TIN/NPI (Table 30) and the final polices that apply if there is no final score associated with a TIN/NPI from the performance period (Table 31).

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	transition year. For groups submitting data using the TIN identifier, CMS will apply the group final score to all the TIN/NPI combinations that bill under that TIN during the performance period. For individual MIPS eligible clinicians submitting data using TIN/NPI, CMS will use the final score associated with the TIN/NPI that is used during the performance period. For eligible clinicians in MIPS APMs, CMS will assign the APM Entity group's final score to all the APM Entity Participant Identifiers that are associated with the APM Entity. For eligible clinicians that participate in APMs for which the APM scoring standard does not apply, CMS will assign a final score using either the individual or group data submission assignments. CMS also previously finalized hierarchy rules if a TIN/NPI has more than one final score associated with the same TIN/NPI from the performance period. Beginning with the 2020 MIPS payment year, CMS proposes to modify the above policies to address the addition of virtual groups, such that: • CMS will continue to prioritize using the APM Entity final score over any other score for a TIN/NPI. This requires CMS to use waiver authority under the Innovation Center to waive MACRA requirements at section 1848(q)(5)(I)(i)(I) and (II) of the Act for assessing and scoring MIPS eligible clinicians in virtual groups based on the combined performance of all MIPS eligible clinicians in the virtual group. The use of waiver authority is to avoid creating competing incentives between MIPS and the APM. • CMS also proposes to modify the hierarchy to state that if a MIPS eligible clinician is not in an APM Entity and is in a virtual group, the MIPS eligible clinician would receive the virtual group final score over any other final score. The hierarchy policies remain unchanged for TIN/NPIs who are not in an APM Entity or virtual group.	
Establishing the Performance Threshold	For the 2020 MIPS payment year, CMS proposes to set the performance threshold at 15 points.	***CMS is finalizing this policy as proposed and codifying at §414.1405(b)(5). (p. 798)***
Additional Performance Threshold for Exceptional Performance	For the 2020 MIPS payment year, CMS proposes to again set the additional performance threshold at 70 points.	***CMS is finalizing this policy as proposed and codifying at §414.1405(d)(4). (p. 803)***

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Scaling/Budget Neutrality	CMS does not propose any changes to the MIPS payment adjustment factors, or to the scaling and budget neutrality requirements as they are applied to MIPS payment adjustment factors relative to policies finalized in the 2017 QPP final rule. Likewise, CMS does not propose any changes for determining the additional MIPS payment adjustment factors.	No changes proposed or finalized. (p. 804)
Application of the MIPS Payment Adjustment Factors	CMS proposes to apply the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, to the Medicare paid amount for items and services paid under Part B and furnished by the MIPS eligible clinician during the year.	***CMS is finalizing this policy as proposed. (p. 807)*** In response to questions regarding the application of the MIPS payment adjustment on non-participating clinicians, CMS notes that although it did not address such issues in the proposed rule, CMS intends to address them in rulemaking next year. (p. 806) CMS provides an example (see Figure A) of how various final scores would be converted to an adjustment factor (including potentially an additional adjustment factor) using statutory formulas and final policies (e.g. performance threshold of 15 points, additional performance threshold of 70 points). Table 32 illustrates the changes in payment adjustments from the transition year to the 2020 MIPS payment year based on final policies, as well as the statutorily-required increase in the applicable percent from 4% to 5%. CMS also provides three examples of how, under final policies, MIPS eligible clinicians can achieve a final score at or above the performance threshold starting on p. 812.
Review and Correction of MIPS Final Score		
Feedback and Information to Improve Performance	Beginning July 1, 2018, CMS proposes to provide performance feedback to MIPS eligible clinicians and groups for the quality and cost performance categories for the 2017 performance period, and if technically feasible, for the improvement activities and advancing care information performance categories. CMS proposes to provide this performance feedback at least annually, and as, technically feasible, CMS would provide it more frequently.	***CMS is finalizing these policies as proposed. (p. 825)*** CMS states its goal is to provide more timely feedback under MIPS as the program evolves. CMS notes challenges with providing feedback more frequently, as CMS can only provide feedback as often as data are reported; for MIPS, this is annually for all quality submission mechanisms except for claims and administrative claims. As soon as the data are available on a more frequent basis, CMS can continue exploring the path to provide performance feedback on a more frequent basis. CMS also notes that it is working with stakeholders on an API alpha where

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		registries and other third party intermediaries, as technically feasible, are currently testing real-time feedback capabilities and directly sharing feedback with eligible clinicians or groups. (p. 821)
	CMS proposes that MIPS eligible clinicians who participate in MIPS APMs would receive performance feedback in 2018 and future years of the Quality Payment Program, as technically feasible.	CMS refers readers to the discussion on the APM Scoring Standard for MIPS Eligible Clinicians in MIPS APMs for a discussion of this proposal and comments. (p. 825)
	CMS proposes to furnish performance feedback to eligible clinicians and groups that do not meet the definition of a MIPS eligible clinician but voluntarily report on measures and activities under MIPS. CMS proposes that this would begin with data collected in performance period 2017, and would be available beginning July 1, 2018.	***CMS is finalizing this policy as proposed. (p. 827)***
	Mechanisms. CMS seeks comment on how health IT, either in the form of an EHR or as a supplemental module, could better support the feedback related to participation in the Quality Payment Program and quality improvement in general. CMS also seeks feedback from third party intermediaries one when "real-time" feedback could be provided. Additionally, CMS plans to continue to work with third party intermediaries as CMS continues to develop the mechanisms for performance feedback, to see where CMS may be able to develop and implement efficiencies for the QPP. CMS is exploring options with an API, which could allow authenticated third party intermediaries to access the same data that CMS use to provide confidential feedback to the individual clinicians and groups on whose behalf the third party intermediary reports for purposes of MIPS. CMS' goal is to enable individual clinicians and groups to more easily access their feedback via the mechanisms and relationships they already have established. CMS seeks comments on this approach as CMS continues to develop performance feedback mechanisms.	CMS thanks commenters for their responses to the solicitations but does not detail the nature of the comments. CMS notes that it will consider these comments as it continues to build performance feedback. (p. 830)
	Receipt of Information. CMS discussed its intent to explore the possibility of adding functionality to the CMS-designated feedback system that would allow CMS to use the same mechanisms to also receive information from professionals. CMS seeks comment on the features that could be developed for the expanded use of the feedback mechanism. CMS also intends to utilize existing resources, such as a helpdesk or technical assistance, to help address questions.	CMS thanks commenters for their responses to the solicitations but does not detail the nature of the comments. CMS notes that it will consider these comments as it continues to build performance feedback. (p. 831)

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	Additional Information – Type of Information. CMS proposes, beginning with the performance feedback provided around July 1, 2018, to make available to MIPS eligible clinicians and eligible clinicians information about the items and services for which payment is made under Title 18 that are furnished to individuals who are patients of MIPS eligible clinicians and eligible clinicians by other suppliers and providers of services. CMS proposes to include as much of the following data elements as technically feasible: the name of such suppliers and providers of services; the types of items and services furnished and received; the dollar amount of services provided and received; and the dates that items and services were furnished. CMS proposes that the additional information would include historical data regarding the total, and components of, allowed charges (and other figures as determined appropriate). CMS proposes that this information be provided on the aggregate level; one exception may be data on items and services, as CMS could consider providing this data at the patient level, if clinicians find that level of data to be useful, although CMS notes it may contain personally identifiable information and protected health information. CMS proposes the date range for making this information available would be based on what is most helpful to clinicians, such as the most recent data CMS has available, which as technically feasible would be provided from a 3 to 12- month period. CMS proposes to make this information available via the QPP Website, and as technically feasible, as part of the performance feedback. Finally, because data on items and services furnished is generally kept confidential, CMS proposes that access would be provided only after secure credentials are obtained. CMS requests comment on these proposals.	***CMS is finalizing these policies as proposed. (p. 834)***
	Performance Feedback Template. CMS seeks comment on the structure, format, and content (e.g., detailed goals, data fields, and elements) that would be useful for MIPS eligible clinicians and groups to include in performance feedback, including the data on items and services furnished, as discussed above. CMS seeks comment on what to term "performance feedback."	CMS thanks commenters for their responses to the solicitations but does not detail the nature of the comments. CMS will take the feedback into consideration as it continues to build performance feedback. ***CMS invites clinicians and groups that may have ideas they want to share, or if they would like to participate in user testing to email partnership@cms.hhs.gov.*** CMS intends for this performance feedback to be available in the new format on the 2017 performance period by summer 2018, after the 2017 reporting closes. (p. 835)
Targeted Review	CMS does not propose any changes to the targeted review process, but provides information on policies finalized in the CY 2017 QPP final rule.	No policies proposed or finalized.
Data Validation and	CMS proposes to codify policies below in regulation text, as well as make	***CMS is finalizing its policy as proposed to require all MIPS eligible***

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Auditing	the following specified updates or corrections. • All MIPS eligible clinicians and groups that submit data and information to CMS for purposes of MIPS must certify (rather than attest, as previously finalized) to the best of their knowledge that the data submitted to CMS is true, accurate, and complete. The certification must accompany the submission. • CMS may reopen and revise a MIPS payment determination in accordance with the rules set forth at §§405.980 through 405.986 (corrected from 405.984). • All MIPS eligible clinicians or groups that submit data and information to CMS for purposes of MIPS must retain such data and information for a period of 10 years from the end the MIPS Performance Period. CMS also restated its final policies to recoup incorrect payment amounts from MIPS eligible clinicians and groups by the amount of any debts owed to CMS, and to use data validation and audits as educational opportunities. CMS will also continue to include education and support for those clinicians and groups selected for audit.	***clinicians and groups that submit data and information to CMS for purposes of MIPS to certify to the best of their knowledge that the data submitted to CMS is true, accurate, and complete. Further, CMS finalizes that the certification by the MIPS eligible clinician or group must accompany the submission and be made at the time of the submission. CMS is also finalizing with clarification that it may reopen and revise a MIPS payment adjustment rather than a payment determination. CMS is also finalizing its proposal that CMS may reopen and revise a MIPS payment adjustment in accordance with the rules set forth at §§405.980 through 405.986. Finally, CMS is finalizing its proposal with modification that all MIPS eligible clinicians and groups that submit data and information to CMS for purposes of MIPS must retain such data and information for 6 years, rather than 10 years, from the end of the MIPS performance period.*** These changes would be added to regulation text at §414.1390. (p. 843) In response to comments that requested additional guidance regarding the specific data that must be retained for auditing purposes, CMS provided additional detail starting on p. 841.
Third Party Data Submission		
General	*Expansion to Virtual Groups*. CMS proposed to allow third party intermediaries to also submit on behalf of virtual groups. *Certification*. CMS proposes to add a requirement stating that all data submitted to CMS by a third party intermediary on behalf of a MIPS eligible clinician, group or virtual group must be certified by the third party intermediary to the best of its knowledge as true, accurate, and complete. It also proposes that this certification occur at the time of the submission and accompany the submission.	***CMS finalized these policies as proposed*** (p. 848): • ***To revise §414.1400(a)(1) to include virtual groups; and*** • ***A requirement at §414.1400(a)(5) that all data submitted to CMS by a third party intermediary on behalf of a MIPS eligible clinician, group or virtual group must be certified by the third party intermediary to the best of its knowledge as true, accurate, and complete; and require that this certification occur at the time of the submission and accompany the submission.*** CMS understands that third party intermediaries may not always be the original source of data. In the 2017 QPP final rule with comment period (81 FR 77388), CMS clarified that MIPS eligible clinicians are ultimately responsible for the data that is submitted by their third party intermediary and expect that MIPS eligible clinicians and groups should ultimately hold their third party intermediary accountable for accurate reporting. However, CMS also expects third party intermediaries to develop processes to ensure that the data and information they submit to us on behalf of clinicians is true, accurate, and complete.

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		In response to requests that the certification requirement be at the registry level. CMS clarifies that the third party intermediary must certify each submission and that the certification must be for each MIPS eligible clinician, group, and virtual group on whose behalf it is submitting data to CMS. CMS also clarifies that a third party intermediary that knowingly submits false data to the government, whether the third party intermediary was the original source of the data or not, would be subject to penalty under federal law. Finally, CMS clarifies that the certification it is requiring at §414.1400(a)(5) is imposed upon a third party intermediary and the data it submits to CMS on behalf of clinicians, while the certification requirement it finalized in the 2017 QPP Final Rule (81 FR 77362) is imposed upon MIPS eligible clinicians and groups that submit data and information to CMS for purposes of MIPS. CMS believes both are important and non-duplicative.
Qualified Clinical Data Registries (QCDRs)	*Establishment of an Entity Seeking to Qualify as a QCDR.* CMS does not propose any changes to the criteria to qualify as a QCDR, established in the 2017 QPP Final Rule.	CMS maintained these policies (p. 848).
	Self-Nomination Process. CMS proposes, beginning with the 2019 performance period, a simplified process in which existing QCDRs in good standing may continue their participation in MIPS, by attesting that the QCDR's approved data validation plan, cost, measures, activities, services, and performance categories offered in the previous year's performance period of MIPS have minimal or no changes and will be used for the upcoming performance period. For future years, beginning with the 2018 performance period, CMS proposes that self-nomination information must be submitted via a web-based tool, and to eliminate the submission method of email. In the CY 2017 Quality Payment Program final rule (81 FR 77365 through 77366), CMS finalized the self-nomination period for the 2018 performance period to begin on September 1 of the year prior to the applicable performance period until November 1 of the same year.	***CMS finalized these policies, with clarification, at §414.1400(b)*** (p. 862). For the 2018 performance period and future years of the program, the QCDR must self-nominate from September 1 of the prior year until November 1 of the prior year. Entities must self-nominate and provide all information requested by CMS at the time of self-nomination. ***Beginning with the 2018 performance period, QCDR self-nominations must be submitted via a web-based tool.*** ***Beginning with the 2019 performance period, a simplified self-nomination process would be available for QCDRs in good standing.*** More specifically, previously approved QCDRs in good standing (that are not on probation or disqualified) that wish to self-nominate using the simplified process can attest, in whole or in part, that their previously approved form is still accurate and applicable. For previously approved QCDRs in good standing with no changes to their approved self-nomination application from the previous year of MIPS, they may attest

as such. For previously approved QCDRs in good standing that wish to self-nominate and have minimal or substantive changes, CMS elaborates on what would be required:

- Those with minimal changes can attest to aspects of their previously submitted form that remain the same, but would additionally be required to outline any minimal changes for CMS review and approval. Minimal changes include, but are not limited to: limited changes to performance categories, adding or removing MIPS quality measures, and adding or updating existing services and/or cost information.
- Those with substantive changes may submit those substantive changes while attesting that the remainder of their application remains the same from the previous year. Substantive changes include, but are not limited to: updates to existing (approved) QCDR measure specifications, new QCDR measures for consideration, changes in the QCDR's data validation plan, or changes in the QCDR's organizational structure (e.g., if a regional health collaborative or specialty society wishes to partner with a different data submission platform vendor that would support the submission aspect of the QCDR).

The information required to be submitted for any changes would be the same as that required under the normal self-nomination process as discussed elsewhere in this rule.

CMS clarifies that having qualified as a QCDR in a prior year does not automatically qualify the entity to participate in MIPS as a QCDR in subsequent performance periods (82 FR 30159).

CMS continues to believe that an annual self-nomination process is the best process to ensure accurate information is conveyed to MIPS individual eligible clinicians and groups and accurate data is submitted for MIPS. CMS is concerned that utilizing a multi-year approval process would restrict QCDRs by having them support the same fixed services they had for the first year, and would not provide QCDRs with the flexibility to add or remove services, measures, and/or activities based on their QCDR capabilities for the upcoming program year or to make changes to their organizational structure. This would also create complications for placing QCDRs who perform poorly (during the first year) on probation or disqualifying them. Moreover, a multi-year approval process would not take into consideration potential changes in criteria or requirements of

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		participation for QCDRs, that may occur as the MIPS program develops through future program years. CMS will revisit this topic once it has gained additional experience with the self-nomination process under MIPS. ***In the interim, CMS seeks additional feedback from stakeholders as to how CMS' concerns with multi-year approvals of QCDRs can be resolved.***
	Information Required at the Time of Self-Nomination. CMS proposes to replace the term "non-MIPS measures" with "QCDR measures" for future program years, beginning with the 2018 performance period. However, it does not propose any other changes to the information a QCDR must provide to CMS at the time of self-nomination finalized in the 2017 QPP final rule.	***CMS finalized its policy to replace "non-MIPS measures" with the term "QCDR measures," as proposed*** (p. 865).
	QCDR Criteria for Data Submission. While CMS does not propose any changes to the criteria for data submission in this proposed rule, it notes clarifications to existing criteria. For data submissions, QCDRs: • Must have in place mechanisms for transparency of data elements and specifications, risk models and measures (i.e., listed on the QCDR's website). • Approved QCDRs may post the MIPS quality measure specifications on their website, if they so choose, but they must be replicated exactly the same as the MIPS quality measure specifications posted the CMS website. • Enter into and maintain with its participating MIPS eligible clinicians, an appropriate Business Associate Agreement that complies with the HIPAA Privacy and Security Rules. • Ensure that Business Associate Agreement provides for the QCDR's receipt of patient-specific data from an individual MIPS eligible clinician or group, as well as the QCDR's disclosure of quality measure results and numerator and denominator data or patient specific data on Medicare and non-Medicare beneficiaries on behalf of MIPS eligible clinicians and groups. • Must provide timely feedback at least 4 times a year, on all of the MIPS performance categories that the QCDR will report to CMS. • For purposes of distributing performance feedback to MIPS eligible clinicians, CMS encourages QCDRs to assists MIPS eligible clinicians in the update of their email addresses in CMS systems- including PECOS and the Identity and Access System- so that they have access to feedback as it becomes available on	CMS maintained these policies (p. 866).

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	www.qpp.cms.gov and have documentation from the MIPS eligible clinician authorizing the release of his or her email address.	
	QCDR Measure Specifications Criteria. CMS did not propose any changes to the QCDR measure specifications criteria and refers readers to the 2017 QPP final rule (81 FR 77374 through 77375) for these requirements. However, it did provide clarification on some issues: • QCDR measures submitted for consideration should align with CMS' Measures Development Plan. • CMS will likely not approve retired measures that were previously in one of CMS's quality programs, such as PQRS, if proposed as QCDR measures. This includes measures that were retired due to being topped out or due to due to a change in the evidence supporting the use of the measure. • QCDRs must publicly post measure specifications (no later than 15 *calendar* days following approval of these measure specifications) for each QCDR measure it intends to submit for MIPS. Additionally, beginning with the 2018 performance period and for future program years, CMS proposes that if a QCDR would like to report on an existing QCDR measure that is owned by another QCDR, they must have permission from the QCDR that owns the measure that they can use the measure for the performance period. Permission must be granted at the time of self-nomination, so that the QCDR that is using the measure can include the proof of permission for CMS to review.	CMS maintains its previously finalized policies related to QCDR measure specifications (p. 868). ***CMS also finalized its proposals in this section with modification*** (p. 873). ***For the 2018 performance period and future performance periods, QCDRs can report on an existing QCDR measure that is owned by another QCDR with appropriate permissions***. CMS clarifies that it will assign QCDR measure IDs after the QCDR measure has been approved, and the same measure ID must be used by other QCDRs that have received permission to also report the measure. CMS also clarifies that QCDRs must publicly post specifications no later than 15 *calendar* days following its approval of the measures specifications.
	Identifying QCDR Quality Measures. CMS did not propose any changes to the criteria on how to identify QCDR quality measures. However, it clarified that QCDRs are not limited to reporting on QCDR measures, and may also report on MIPS measures.	CMS maintains these policies (p. 873), but notes its interest in elevating the standards for which QCDR measures are selected and approved for use. ***For consideration in future rulemaking, CMS seeks comment on whether the standards used for selecting and approving QCDR measures should align more closely with the standards used for CMS' Call for Quality Measures process*** **(described at 81 FR 77151).**
Health IT Vendors That Obtain Data from MIPS Eligible Clinicians' Certified EHR Technology (CEHRT)	CMS seeks comment for future rulemaking regarding the potential shift to seeking alternatives which might fully replace the QRDA III format in the QPP in future program years.	CMS will take feedback provided into consideration for possible inclusion in future rulemaking (p. 874).
Qualified Registries	CMS proposes, beginning with the 2019 performance period, a simplified	***CMS finalized these policies, with clarification, at §414.1400(g)*** (p. 884).

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	process in which existing qualified registries in good standing may continue their participation in MIPS by attesting that its approved data validation plan, cost, approved MIPS quality measures, services, and performance categories offered in the previous year's performance period of MIPS have minimal or no changes and will be used for the upcoming performance period. CMS also seeks comments on potentially allowing qualified registries to utilize a multi-year approval process, in which they would be approved for a continuous 2-year increment in which qualified registries can only make minor changes (e.g., including a performance category, or a MIPS quality measure, all of which are already considered a part of the MIPS program). For the 2018 performance period and beyond, CMS proposes that self-nomination information must be submitted via a web-based tool, and to eliminate the submission method of email.	For the 2018 performance period and future years of the program, the qualified registry must self-nominate from September 1 of the prior year until November 1 of the prior year. Entities must self-nominate and provide all information requested by CMS at the time of self-nomination. ***Beginning with the 2018 performance period, qualified registry self-nominations must be submitted via a web-based tool.*** ***Beginning with the 2019 performance period, a simplified self-nomination process would be available for registries in good standing.*** Specifically, beginning with the 2019 performance period, previously approved registries in good standing (that are not on probation or disqualified) that wish to self-nominate using the simplified process can attest, in whole or in part, that their previously approved form is still accurate and applicable. For previously approved qualified registries in good standing with no changes to their approved self-nomination application from the previous year of MIPS, they may attest as such. For previously approved qualified registries in good standing that wish to self-nominate and have minimal or substantive changes, CMS elaborates on what would be required: • Those with minimal changes can attest to aspects of their previously submitted form that remain the same, but would additionally be required to outline any minimal changes for CMS review and approval. Minimal changes include, but are not limited to: limited changes to performance categories, adding or removing MIPS quality measures, and adding or updating existing services and/or cost information. • Those with substantive changes may submit those substantive changes while attesting that the remainder of their application remains the same from the previous year. Substantive changes include, but are not limited to: changes in the qualified registry's data validation plan or changes in the qualified registry's organizational structure.
CMS-Approved Survey Vendors	In order to provide a final list of CMS-approved survey vendors early in the timeframe during which groups can elect to participate in the CAHPS for MIPS survey, CMS proposes that, beginning with the 2018 performance period, the vendor application deadline would be January 31st of the applicable performance year or a later date specified by CMS, rather than April 30th.	***CMS finalized this policy as proposed*** (p. 888). Vendors are required to undergo the CMS approval process for each year in which the survey vendor seeks to transmit survey measures data to CMS.

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Probation and Disqualification of a Third Party Intermediary	CMS does not propose any changes to the process of probation and disqualification of a third party intermediary.	Starting on p. 889, CMS clarifies that at §414.1400(k), it finalized the process for placing third party intermediaries on probation and for disqualifying such entities for failure to meet certain standards (81 FR 77386). More information regarding the probation and disqualification process can be found in the 2018 QPP proposed rule (81 FR 30163). CMS also clarifies the following previously finalized policies (81 FR 77388): • MIPS eligible clinicians are ultimately responsible for the data that are submitted by their third party intermediaries and expect that MIPS eligible clinicians and groups should ultimately hold their third party intermediaries accountable for accurate reporting. • CMS will consider from the MIPS eligible clinicians and groups perspective, cases of vendors leaving the marketplace during the performance period on a case by case basis, but will not consider cases prior to the performance period.
Auditing of Third Party Intermediaries Submitting MIPS Data	CMS proposes a change to this policy to clarify that the entity must retain all data submitted to CMS for purposes of MIPS for a minimum of 10 years *from the end of the MIPS performance period*.	***CMS finalized this policy with modification*** (p. 890). ***Due to concerns about the time and financial burden of managing, storing, and retrieving data and information, CMS is finalizing a 6-year retention requirement.*** CMS also notes that, as finalized in the CY 2017 QPP final rule (81 FR 77389-77390) for the purposes of auditing, CMS may request any records or data retained for the purposes of MIPS for up to 6 years and 3 months. While CMS did not propose any changes or updates to this policy in the 2018 QPP proposed rule, it is updating §414.1400(j)(3) to reflect this policy and to allow it to request any records or data retained for the purposes of MIPS for up to 6 years from the end of the MIPS performance period.
Public Reporting on Physician Compare		
General	CMS has continued to expand public reporting through Physician Compare using a phased approach. This expansion includes publicly reporting individual eligible clinician and group-level QCDR measures starting with 2016 data available for public reporting in late 2017, as well as the inclusion of a 5-star rating based on a benchmark in late 2017 based on 2016 data (80 FR 71125 and 71129), among other additions.	***CMS finalized its proposed changes and additions to the regulation text at §414.1395(a) through §414.1395(d)*** (p. 900). In response to questions about how CMS determines which measures meet the public reporting standards, CMS noted that additional information about its testing and findings will be shared on the Physician

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	This expansion will continue under the MACRA. Sections 1848(q)(9)(A) and (D) of the Act facilitates the continuation of CMS' phased approach to public reporting by requiring the Secretary to make available on Physician Compare, in an easily understandable format, individual MIPS eligible clinician and group performance information, including: • The MIPS eligible clinician's final score; • The MIPS eligible clinician's performance under each MIPS performance category (quality, cost, improvement activities, and advancing care information); • Names of eligible clinicians in Advanced APMs and, to the extent feasible, the names of such Advanced APMs and the performance of such models; and • Aggregate information on the MIPS, posted periodically, including the range of final scores for all MIPS eligible clinicians and the range of the performance of all MIPS eligible clinicians for each performance category. This information will be publicly reported consistent in accordance with the public reporting standards previously authorized under sections 10331(a)(2) and 10331(b) of the Affordable Care Act and summarized in previous rulemaking (80 FR 71118 through 71120). Section 1848(q)(9)(B) of MACRA also requires that this information indicate, where appropriate, that publicized information may not be representative of the eligible clinician's entire patient population, the variety of services furnished by the eligible clinician, or the health conditions of individuals treated. Section 104(e) of the MACRA requires the Secretary to make publicly available, on an annual basis, in an easily understandable format, information for physicians and, as appropriate, other eligible clinicians related to items and services furnished to people with Medicare. This utilization data must include, at a minimum: • Information on the number of services furnished under Part B, which may include information on the most frequent services furnished or groupings of services; • Information on submitted charges and payments for Part B services; and • A unique identifier for the physician or other eligible clinician	Compare Initiative page. In response to requests that CMS not report quality or cost measures for the first 3 years a measure is in use, CMS stated that it does find added value in waiting to provide the public with potentially valuable information after clinicians and groups have had a chance to review and understand the initial results and the measure is deemed to meet all public reporting criteria. Nevertheless, it will carefully evaluate cost measure data after the first year, understanding this is new and complex information. With the exception of data that must be mandatorily reported on Physician Compare, if certain cost measure data is determined under CMS' established public reporting standards not to be suitable for public reporting, it will not be reported. In response to concerns that a 30-day preview period is too short, CMS does not believe that extending the preview period will provide additional value since, clinicians and groups typically have not initiated the preview process until near the end of the process. However, CMS is actively working to ensure the preview process is more streamlined and user-friendly, which should also facilitate more easily obtaining the information needed to assist with previewing data. It is also actively working to provide more information about the preview timeline and process each year through stakeholder outreach and the Physician Compare listserv.

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	that is available to the public, such as an NPI. Utilization data regarding is currently available here. This information is integrated on the Physician Compare website via the downloadable database each year using the most current data, starting with the 2016 data, targeted for initial release in late 2017 (80 FR 71130). In this section, CMS proposes the following clarifying revisions to the public reporting regulation: • At §414.1395(a), to more completely and accurately reference the data available for public reporting on Physician Compare and to remove from the heading and text references to "MIPS" and "public website" and instead reference "Quality Payment Program" and "Physician Compare." • To add paragraphs (b), (c), and (d) at §414.1395, to capture previously established policies for Physician Compare relating to the public reporting standards, first year measures, and the 30-day preview period. The public reporting standards require data included on Physician Compare to be statistically valid, reliable, and accurate; be comparable across submission mechanisms; and, meet the reliability threshold. To be included on the public facing profile pages (versus downloadable database), the data must also resonate with website users, as determined by CMS. In regards to first year measures, CMS does not publicly report any measure in its first year of use in the quality and cost performance categories. After the first year, CMS reevaluates measures to determine when and if they are suitable for public reporting. CMS also provides a 30-day preview period for any clinician or group with QPP data before the data are publicly reported on Physician Compare.	
Final Score, Performance Categories, and Aggregate Information	For 2018 data available for public reporting in late 2019 and future years, CMS again proposes to publicly report on Physician Compare, either on profile pages or in the downloadable database, the final score for each MIPS eligible clinician and the performance of each MIPS eligible clinician for each performance category, and to periodically post aggregate information on the MIPS, including the range of final scores for all MIPS eligible clinicians and the range of performance of all the MIPS eligible clinicians for each performance category, as technically feasible. CMS will use statistical testing and user testing, as well as consultation with the Physician Compare Technical Expert Panel convened by its contractor, to	***CMS finalized these policies as proposed*** (p. 905). Analysis and user testing of the final score and aggregate information, as with all data available for public reporting, will be ongoing, and CMS will actively work to share the results of this testing with stakeholders through outreach and via the Physician Compare Initiative page. User testing will also address the concern as to whether these data help patients and caregivers make health care decisions. CMS is taking steps to address concerns around the comparability of data and the "Pick Your Pace" options. Analyses will be done to ensure the chosen participation approach does not lead to non-comparable data on Physician Compare.

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	determine how and where these data are best reported on Physician Compare.	Regarding concerns raised about the interpretation of missing data or a lack of data, this is a concept that has been tested with users under the legacy PQRS program. To date, CMS has found that users understand there are many reasons a clinician or group may not have data on the website, and they understand this is just the start of the public reporting process. Nevertheless, CMS will actively work to ensure that the language on the website and the additional education and outreach conducted for patients and caregivers continues to make this message clear. Finally, CMS recognizes requests that it more actively and frequently share the results of statistical testing and user testing. CMS will actively work to share the results of this testing with stakeholders through outreach and via the Physician Compare Initiative page prior to reporting the data each year.
Quality	For 2018 data available for public reporting in late 2019, and for each year moving forward, CMS again proposes to make all measures under the MIPS quality performance category available for public reporting on Physician Compare, either on profile pages or in the downloadable database, as technically feasible. CMS will continue its policies of not publicly reporting first year quality measures, only reporting those measures that meet reliability thresholds and meet public reporting standards, and including the total number of patients reported on for each measure in the downloadable database. This would include all available measures reported via all available submission methods for both MIPS eligible clinicians and groups. CMS seeks comment on expanding the patient experience data available for public reporting on Physician Compare to include five open-ended questions for the CAHPS for MIPS survey that better capture patient narrative reviews of clinicians.	***CMS finalized these policies as proposed*** (p. 908). CMS will use statistical testing and user testing to determine how and where measures are reported on Physician Compare. CMS will take the feedback provided on expanding the patient experience data on Physician Compare into consideration for possible inclusion in future rulemaking
Cost	For 2018 data available for public reporting in late 2019, and for each year moving forward, CMS again proposes to include on Physician Compare a sub-set of cost measures that are not first year measures and meet the reliability thresholds and public reporting standards, either on profile pages or in the downloadable database, if technically feasible. This includes measures reported via all available submission methods, and applies to both MIPS eligible clinicians and groups.	***CMS finalized these policies as proposed*** (p. 912). CMS will use statistical testing and user testing to determine how and where measures are reported on Physician Compare.

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Improvement Activities	For 2018 data available for public reporting in late 2019, and for each year moving forward as required by MACRA, CMS again proposes to include a subset of improvement activities data on Physician Compare that meet the public reporting standards, either on the profile pages or in the downloadable database, if technically feasible. This includes all available activities reported via all available submission methods, and applies to both MIPS eligible clinicians and groups. CMS also proposes that statistical testing and user testing would determine how and where improvement activities are reported on Physician Compare. For the transition year, CMS excluded first year activities from public reporting. However, CMS proposes to publicly report first year activities, if all other reporting criteria are satisfied, starting with year two (2018 data available for public reporting in late 2019).	***CMS finalized these policies as proposed*** (p. 915). For those eligible clinicians or groups that successfully meet the improvement activities performance category requirements, this information will be posted on Physician Compare as an indicator. CMS has already started testing this data with website users and have found that this data is not only easily understood, but believed to be of great value to website users. CMS also notes that because it is just indicating if an activity was completed and not also reporting performance on the activity, it does not find added benefit in waiting beyond year 2 of the QPP to report first year activities.
Advancing Care Information	***For 2018 data available for public reporting in late 2019, and for each year moving forward as required by MACRA, CMS again proposes to include an indicator on Physician Compare for any eligible clinician or group who successfully meets the advancing care information performance category, as technically feasible. Also, as technically feasible, CMS proposes to include additional indicators, including but not limited to, objectives, activities, or measures specified in the ACI performance sections of this proposed rule (e.g., identifying if the eligible clinician or group scores high performance in patient access, care coordination and patient engagement, or health information exchange). These will need to meet the public reporting standards applicable to data posted on Physician Compare, either on the profile pages or in the downloadable database. These policies would apply to both MIPS eligible clinicians and groups. CMS will use statistical testing and website user testing to determine how and where objectives, activities, and measures are reported on Physician Compare.*** ***As with improvement activities, CMS also proposes to allow first year ACI objectives, activities, or measures.***	***CMS finalized these policies as proposed (p. 918). CMS notes that it will indicate "high" performance, as technically feasible and appropriate, but will not indicate "low" performance in year 2 of the Quality Payment Program (2018 data available for public reporting in late 2019). CMS will revisit the value of indicating "low" performance for possible consideration in future rulemaking. To clarify, "successful completion" of this performance category will be defined as obtaining the base score of 50%, as supported by commenters. "High" performance will be defined as obtaining score of 100%.***
Available Benchmark of Care (ABC) Methodology	Starting with transition year data (2017 data available for public reporting in late 2018) and for each year of the QPP, CMS proposes to use the ABC™ methodology to determine a benchmark for the quality, cost, improvement activities, and advancing care information data, as feasible and appropriate, by measure and by reporting mechanism for purposes of Physician Compare. CMS also proposes to use this benchmark to determine a 5-star rating for each MIPS measure, as feasible and appropriate. As previously finalized, only those measures	***CMS finalized, as proposed, to use the ABC™ methodology to determine a benchmark for the quality, cost, improvement activities, and advancing care information data, as feasible and appropriate, by measure and by submission mechanism for each year of the QPP, starting with the transition year (2017 data available for public reporting in late 2018) and each year forward. It is also finalizing its proposal to use this benchmark as the basis of a 5-star rating for each available measure, as feasible and appropriate. Only those measures***

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	that meet the public reporting standards would be considered, and the benchmark would be based on the most recently available data. Also as previously finalized (80 FR 71129), CMS expects to publicly report the benchmark and 5-star rating for the first time on Physician Compare in late 2017 using the 2016 PQRS performance scores for both clinicians and groups. The ABC™is a well-tested, data-driven methodology that allows CMS to account for all of the data collected for a quality measure, evaluate who the top performers are, and then use that to set a point of comparison for all of those clinicians or groups who report the measure. ABC™ starts with the pared-mean, which is the mean of the best performers on a given measure for at least 10% of the patient population – not the population of reporters. In other words, the benchmark is derived by calculating the total number of patients in the highest scoring subset (i.e., reporters that represent 10% of all patients in the denominator across all reporters for that measure) receiving the intervention or the desired level of care, or achieving the desired outcome, and dividing this number by the total number of patients that were measured by the top performing doctors. This would produce a benchmark that represents the best care provided to the top 10% of patients by measure, by submission mechanism. To account for low denominators, CMS will use a beta binomial model adjustment, which moves extreme values toward the average for a given measure (rather than the suggested Bayesian Estimator, which moves extreme values toward 50%. Through analyses, CMS has found that the beta binomial method is a more methodologically sophisticated approach to address the issue of extreme values based on small sample sizes. It ensures that all clinicians are accounted for and appropriately figured in to the benchmark.	***that meet the public reporting standards will be considered for benchmarking and star ratings, and the benchmark will be based on the most recently available data each year*** (p. 927). An example of how the ABC methodology is applied can be found on p. 920. In regards to CMS' decision to employ a 5-star rating system, CMS conducted outreach with stakeholders and determined the best method for determining the 5-star categories based on the benchmark would be to use the ***equal ranges method***. This method is intuitive to interpret, and has tested well with patients and caregivers. Testing has shown that the equal ranges method best reflects true performance on the measure (rather than a forced distribution) and generates more stable star rating cut-offs than the other methods evaluated. CMS also expects star rating assignments based on the equal ranges method to be more stable across years allowing the ability to better assess year-to-year performance. The equal ranges method also provides a more reliable and meaningful classification than other methods evaluated. That is, using the equal ranges ensures that a 4-star performance is statistically better than and distinct from a 3- star performance on a measure and so forth. Clinicians or groups who meet or exceed the benchmark for a measure (by reporting mechanism) will be assigned 5 stars for the measure. The equal ranges method is based on the difference between the benchmark and the lowest performance score for a given measure and uses that range to assign 1 to 4 stars (e.g., the 4-star cut-off is one quarter of the distance between the ABC™ benchmark and the lowest performance score). A more detailed description of how the equal ranges method will be used to assign stars can be found on p. 922. Additional information about this star attribution method can also be found on the Physician Compare Initiative page. In response to concerns about CMS using the ABC™ methodology instead of the decile approach used for MIPS scoring, CMS notes that it is not always ideal or necessary to use the same methodology for scoring and public reporting given the unique considerations and goals of each. CMS reviewed the benchmark and decile breaks being used to assign points and determine payment under MIPS (see 82 FR 30168 through 30169). This approach was not considered ideal for public reporting for several reasons. A primary concern was that the decile approach, when

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		used for public reporting, would force a star rating distribution inconsistent with the raw distribution of scores on a given measure. If applied to star ratings, there would need to be an equal distribution of clinicians in each of the star rating categories. Under the ABC™ methodology, if the majority of clinicians performed well on a measure, the majority would receive a high star rating. On the other hand, if CMS used the decile approach, some clinicians would be reported as having a "low" star rating despite their relative performance on the measure. Recognizing the public's request for more information to better understand this overall approach, CMS notes that resources have been added to the Physician Compare Initiative page that cover these topics and explain the benchmark methodology, the star rating attribution process using the equal ranges method, and analyses that have been conducted in preparation for the release of the first star ratings.
Voluntary Reporting	CMS proposes to make available for public reporting all data submitted voluntarily across all MIPS performance categories, regardless of submission method, by clinician and groups not subject to the MIPS payment adjustments, as technically feasible, starting with year 2 of the QPP and for each year moving forward. During the 30-day preview period, these clinicians and groups would have the option to opt out of having their data publicly reported on Physician Compare.	***CMS finalized this policy as proposed*** (p. 929). It reiterates if an eligible clinician or group that is not subject to the MIPS payment adjustments chooses to submit quality, cost (if applicable), improvement activity, or advancing care information, these data will become available for public reporting. During the 30-day preview period, these eligible clinicians and groups will have the option to ***opt out*** of having their data publicly reported on Physician Compare. If they do not actively take the action to opt out at this time, their data will be available for inclusion on Physician Compare if the data meet all public reporting standards and the minimum reliability threshold.
Publicly Reporting APM Data	As required by statute, CMS again proposes to publicly report the names of eligible clinicians in Advanced APMs and the names and performance of Advanced APMs and APMs that are not considered Advanced APMs under the QPP starting with year 2 and moving forward, as technically feasible. CMS also again proposes to continue to find ways to more clearly link clinicians and groups and the APMs they participate in on Physician Compare, as technically feasible.	***CMS finalized these policies as proposed*** (p. 931).
Stratification of Social Risk Factors	CMS seeks comment on, potentially in the future, accounting for social risk factors through public reporting on Physician Compare.	CMS will take feedback provided into consideration for possible inclusion in future rulemaking.
Board Certification	CMS proposes to add additional Board Certification information to the Physician Compare website. CMS currently includes American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), and American Board of Optometry (ABO) data as part of clinician profiles	***CMS finalized these policies as proposed*** (p. 936), ***including its proposal to add ABWMS Board Certification information to Physician Compare***. Boards should contact the Physician Compare support team at

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	on Physician Compare. For all years moving forward, CMS would establish a process for reviewing interest from other boards on a case-by-case basis. The board would need to demonstrate that it: fills a gap in currently available board certification information listed on Physician Compare; can make the necessary data available; and if appropriate, can make arrangements and enter into agreements to share the needed information for inclusion on Physician Compare. CMS also proposed to add the American Board of Wound Medicine and Surgery (ABWMS) to Physician Compare. The ABWMS has shown interest in being added to the site, has demonstrated that they have the data to facilitate inclusion of this information on the website, and fills a gap for a specialty that is not currently covered by the ABMS.	PhysicianCompare@Westat.com to indicate interest and initiate the review and discussion process. CMS will provide more technical information on the finalized process and selection criteria, as well as any boards selected for inclusion, on the Physician Compare Initiative page.

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Definitions and Regulatory Text Changes		
General	CMS proposes to make alterations to the list of definitions it uses for implementation of the APM Incentive Payment: **Strike**: • QP Performance Period: January 1 to August 31 of the calendar year that is 2 years prior to the payment year **Add**: • All-Payer QP Performance Period: January 1 – June 30 of the calendar year that is 2 years prior to the payment year; • Medicare QP Performance Period: January 1 – August 31 of the calendar year that is 2 years prior to the payment year	***CMS did not finalize this proposal to strike "QP Performance Period" and differentiate between an All-Payer and Medicare QP performance periods because it is not finalizing its proposal to create a separate All-Payer QP Performance Period*** (p. 939). CMS will continue to use the term "QP Performance Period" (Jan 1 – Aug 31) under both the Medicare Option and All-Payer Combination Option.
	Attributed Beneficiary: CMS proposes to change the definition of Attributed Beneficiary so that it only applies to Advanced APMs and not to Other Payer Advanced APMs (given that under the All-Payer Combination option, CMS would not receive information about attributed beneficiaries for the Other Payer Advanced APMs).	***CMS finalized its revised definition of "Attributed Beneficiary"*** (p. 940).
	APM Entity Definition Alterations • APM Entity: CMS proposes to revise the definition to clarify that a payment arrangement with a non-Medicare payer is an Other Payer Arrangement. • Medicaid APM: CMS proposes to make technical changes to the definition to clarify that these arrangements must meet the Other Payer Advanced APM criteria. • Advanced APM Entity: CMS proposes to replace Advanced APM Entity where it appears through the regulations with "APM Entity". • Advanced APM Entity Group: CMS proposes to replace Advanced APM Entity Group with "APM Entity group" where it appears in regulation.	***CMS finalized these changes as proposed*** (p. 942).
	Monitoring and Program Integrity Provisions (§414.1460): CMS makes	***CMS finalized these provisions with one modification: CMS clarified that***

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	changes to the regulatory text to reflect policies discussed elsewhere in the proposed rule. CMS is revising the language to distinguish between scenarios of rescinding QP determinations and recouping APM Incentive Payments given that they are separate policies. CMS is revising when it may rescind a QP determination. CMS is deleting the sentence which provides that an APM incentive payment will be recouped if an audit reveals a lack of support for attested statements provided by eligible clinicians and APM Entities because it believes the provision is duplicative of language that already allows CMS to reopen or recoup any erroneous payments. CMS is streamlining provisions directed at reducing or denying APM incentive payments to clinicians or APM Entities who are terminated from an APM.	***it may rescind a QP determination if a QP is found to be in violation of the terms of the relevant Advanced APM or any relevant Federal, State, or tribal statute or regulation*** (p. 946).
	Additional Information Request: CMS also requests comment on whether other terms are necessary or if there is another framework that might "more intuitively distinguish between APMs and Other Payer Advanced APMs and between APMs and Advanced APMs."	CMS did not review any additional input as request about the terminology.
Bearing Financial Risk for Monetary Loss	**Revenue-Based Standard: Percentage.** CMS proposes for the 2019 and 2020 performance periods to maintain the current Revenue-Based Standard at 8% of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.	***CMS finalized its proposal to maintain the current Revenue-Based Standard at 8% for QP Performance Periods 2019 and 2020*** (p. 962). CMS agreed with comments that time is needed to assess how the current standard affects participation in Advanced APMs before it proposes to change (p. 961). CMS will address the standard for post-2020 QP Performance Periods in future rulemaking.
	CMS requests comment on whether to consider a different (potentially lower) Revenue-Based Standard to assess "Nominal Amount of Risk" for small practices and those in rural areas that are not participating in a Medical Home Model for 2019 and 2020 Medicare QP Performance Periods.	CMS received several comments regarding the potential for setting a different Revenue-Based Standard of Nominal Risk for small practices and practices in rural areas but decline to make any changes at this point (p. 964).
	Revenue-Based Standard: Calculation. The Revenue-Based Standard, is calculated in terms of "average estimated total Medicare Parts A and B revenue of participating APM Entities." CMS recognizes that this can lead to confusion as to whether it is intended to include *payments to all providers and suppliers in an APM Entity* or *only payments directly to the APM Entity itself*. In order to reduce ambiguity, CMS proposes to clarify the Revenue-Based Standard is the "percentage of the average estimated total Medicare Parts A and B revenue of providers and suppliers in participating APM Entities." Under this proposal, CMS would "calculate the estimated total Medicare Parts A and B revenue of providers and suppliers at risk for each APM Entity . . . then calculate an average of all	***CMS reiterated its clarification that the revenue-based nominal amount standards are based on a percentage of the average estimated total Part A and Part B revenue of providers and suppliers in the participating APM Entities*** (p. 960). CMS dismissed suggestions that the generally applicable revenue-based nominal amount standard should only include Part B revenues given that many APM Entities in current Advanced APMs include hospitals and other types of providers that receive both Part A and part B revenues (p. p. 957). CMS also clarified that the Revenue-Based Standard does not limit or cap an individual APM Entity's losses at 8% of that APM Entity's revenues- it only represents a minimum amount of risk to which the average participating APM Entity is exposed in order to qualify as an

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	the estimated total Medicare Parts A and B revenue of providers and suppliers at risk for each APM Entity, and if that average estimated total Medicare Parts A and B revenue at risk for all APM Entities was equal to or greater than 8%, the APM would satisfy the generally applicable revenue-based nominal standard amount."	Advanced APM (p. 959). **APM Investment and Business Risks.** CMS again received comments suggesting that the definition of Financial Risk include investment and business risk. CMS again declined to incorporate these concepts because of the complexity in creating an objective and enforceable standard (p. 959). CMS also stated that it clearly believes that business risk is not the same as performance risk (p. 960).
	Medical Home Model Variation. CMS proposes to change the criterion so that a Medical Home Model will qualify as an Advanced APM if the total annual amount that an APM Entity potentially owes CMS or foregoes to be at least: • 2018: 2% of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities; • 2019: 3% of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities; • 2020: 4% of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities; • 2021 and later: 5% of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.	***CMS finalized its proposal with modification: For Performance Year 2018, CMS no longer believes it would be appropriate to lower the threshold to 2% given that it had already been at 2.5% in 2017. Therefore, CMS finalized the Medical Home Nominal Risk Standard as proposed except for 2018 it will set the standard at 2.5%*** (p. 969).
	Size Limitation. CMS previously finalized a limitation on the applicability of the Medical Home Model Financial Risk and Nominal Amount standards beginning in 2018 to APM Entities with fewer than 50 eligible clinicians in their parent organizations. CMS proposes to exempt from the size limitation requirement any APM Entities enrolled in Round 1 of the Comprehensive Primary Care Plus Model (CPC+). CMS proposes that CPC+ participants who enroll in the future will not be exempt from this requirement.	***CMS finalized its exemption for Round 1 CPC+ APM Entities from the size limitation for the Medical Home Model Financial Risk threshold*** (p. 953).
Qualifying APM Participant (QP) and Partial QP Determination		
General	Medicare previously finalized that the QP Performance Period will run from January 1 through August 31 of the calendar that is 2 years prior to the payment year. CMS proposes to now refer to this period under the Medicare Option as the Medicare QP Performance Period.	***CMS finalized the QP Performance Period from January 1 – August 31 2 years prior to the payment year***, but notes that it established a similar performance period under both the Medicare Option and the All-Payer Option so that they will both be the same (p. 976).

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Advanced APMs Starting or Ending During a Medicare QP Performance Period	CMS proposes to modify the payment amount and patient count threshold calculations for Advanced APMs that start after January 1 or end before August 31 so as to calculate QP Threshold Scores using only data in the numerator and denominator for the dates that APM Entities were able to participate in "active testing" of the Advanced APM so long as APM Entities were able to participate in the Advanced APM for 60 or more continuous days during the Medicare QP Performance Period. (CMS states that it believes an Advanced APM's "active testing period" is the dates within the performance period to a specific model (which is the same time period for which it considers payment amounts or patient counts for QP determinations). An Advanced APM is in "active testing" if APM Entities are "furnishing services to beneficiaries and those services will count toward the APM Entity's performance in the Advanced APM." The "active testing period" does *not* include the period of time when the APM Entity has stopped furnishing services and is only waiting for calculation or receipt of a performance-based payment. CMS notes that if a specific APM Entity joins an Advanced APM between the January 1 and August 31st dates, but other APM Entities participate during the entire Medicare QP Performance Period (January 1 – August 31), CMS considers that Advanced APM to be in "active testing" for the entire Medicare QP Performance Period.)	***CMS finalized this proposal*** (p. 976). CMS also received input that it should broaden the scope of this proposal to the All-Payer Combination. CMS did not make a proposal to do that but also noted that it would not be appropriate as it could be burdensome to payers, APM Entities and eligible clinicians because it requires the submission of additional information (p. 975).
	CMS seeks specific comment on whether it should require that the Advanced APM be in "active testing" for at least 90 days since 90 days is the shortest length of time it would use to make a QP determination.	CMS received some support for expanding the time period to 90 days, but CMS maintained the 60 day time period. CMS cited its belief that 60 days is sufficient time to measure participation in Advanced APMs (p. 974).
Participation in Multiple Advanced APMs	CMS proposes to clarify that if an eligible clinician is determined to be a QP or Partial QP based on participation in multiple Advanced APMs, but one of those APM Entities voluntarily or involuntarily terminates from the Advanced APM before the end of the Medicare QP Performance Period, the eligible clinician is not a QP (or Partial QP).	***CMS finalized this proposal with clarification*** (p. 982). CMS received pushback that it did not state that it would still calculate QP thresholds based on participation in APM Entities that did not terminate. CMS acknowledged that there could be situations where an individual clinician could still achieve QP status if one of the multiple Advanced APMs in which the clinician participates terminates. ***CMS stated that it will evaluate whether the individual eligible clinician's participation in the remaining Advanced APMs would meet the relevant thresholds*** (p. 982).

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All-Payer Combination Option		
Overview	**QP Determinations.** In 2021, CMS will conduct QP determinations sequentially where the Medicare Option is applied before the All-Payer Combination Option. (An eligible clinician only needs to meet the QP thresholds under one to be considered a QP).	CMS reiterated this previously finalized policy to conduct the QP determinations sequentially (p. 984).
	Payment Amount and Patient Counts. CMS previously finalized the annual All-Payer Combination Option QP payment amount and patient count thresholds beginning with Payment Year 2021.	The All-Payer Combination Payment Amount QP Thresholds appear in Table 36 and the All-Payer Combination Patient Count QP Thresholds appear in Table 37.
Other Payer Advanced APM Criteria	**CEHRT.** CMS proposes that it would presume that an Other Payer arrangement would satisfy the 50% CEHRT use criterion if CMS receives information and documentation from the Eligible Clinician as part of the Eligible Clinician Initiated Process (described below) show that the Other Payer arrangement requires the requesting Eligible Clinician to use CEHRT to document and communicate clinical information. CMS also seeks comment on what kind of requirements for CEHRT currently exist in Other Payer arrangements (particularly if they are written to apply at the Eligible Clinician level).	CMS made no additional policy changes on the CEHRT requirement.
	Quality Measures Comparable to MIPS. The Other Payer arrangement requires that quality measures "comparable to measures under the MIPS" Quality Performance Category apply, which means measures that are evidence-based, reliable and valid, and, if available, at least one outcome measure.	CMS made no additional policy changes on the Quality measure "comparable to MIPS" requirement.
	"More than nominal financial risk." • *Marginal Risk of at least 30%:* 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 the APM. To determine when an APM satisfies the Marginal Risk portion of the nominal risk standard, CMS would examine the payment required under the APM as a percentage of the amount by which actual expenditures exceeded expected expenditures. CMS would require that this percentage exceed the required marginal risk percentage regardless of the amount by which actual expenditures exceeded expected expenditures. CMS does not propose to modify the Marginal Risk requirement	***CMS makes no policy changes in the final rule***. CMS acknowledges that the inclusion of a marginal risk requirement creates complexity and could create participation challenges. However, CMS also states that it continues to believe that "the use of a multi-factor nominal amount standard to assess financial risk provides [CMS] with an important guardrail to ensure that Other Payer Advanced APMs will involve true financial risk" (p. 996).

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	for Other Payer Advanced APMs. • *Minimum Loss Rate (MLR) of no greater that 4% of expected expenditures*: MLR is a percentage by which actual expenditures may exceed expected expenditures without triggering financial risk. CMS does not propose to modify the MLR requirement for Other Payer Advanced APMs.	***CMS makes no policy changes in the final rule***. CMS acknowledges that the inclusion of an MLR requirement creates complexity and could create participation challenges. However, CMS also states that it continues to believe that "the use of a multi-factor nominal amount standard to assess financial risk provides [CMS] with an important guardrail to ensure that Other Payer Advanced APMs will involve true financial risk" (p. 996).
	• *Total Risk Calculation*: CMS finalized that the payer arrangement must require APM Entities to bear financial risk for at least 3% of the expected expenditures for which an APM Entity is responsible under the payer arrangement (Benchmark-Based Standard). CMS proposes to add the Revenue-Based Nominal Amount Standard option (used under the generally applicable Advanced APM criteria) to meet the Nominal Amount requirement for Other Payer Advanced APMs. That is, CMS would determine that an Other Payer arrangement would meet the Revenue-Based Nominal Amount Standard if the total amount that an APM Entity potentially owes a payer or forgoes is equal to at least: 8% of the total combined revenues from the payer of providers and suppliers in participating APM Entities (for Performance Periods 2019 and 2020). CMS seeks comment on whether it should consider a lower or higher Revenue-Based Nominal Amount Standard for the 2019 and 2020 All-Payer QP Performance Periods.	***CMS finalized the Other Payer Revenue Based Standard for calculation of Total Risk at 8% for the 2019 and 2020 performance periods as proposed*** (p. 997). CMS also clarified (as it did under the section on Advanced APMs) that to calculate financial risk under the Total Risk Revenue-based Standard, CMS will examine the "total combined revenues of the providers or other entities under the payment arrangement" (p. 998). CMS also addressed comments that the revenue-based nominal amount standard should only include physician revenue. CMS stated that it would be inappropriate to do so because it would not take into account "the wide variety of potential payment arrangements and types of entities in those arrangements." (p. 998). CMS did note however that it has significant operational challenges to identifying whether Other Payer Arrangements satisfy the Revenue-Based Standard when the Other Payer Arrangement does not define risk explicitly in terms of revenue and therefore finalized that the standard will only be applied to Other Payer Arrangements in which risk is explicitly defined in terms of revenue (p. 999).
	An Other Payer Advanced APM need only meet the Nominal Amount assessment under either the Benchmark-Based Standard or the Revenue Based Standard (not both). CMS also seeks comment on the amount and structure of the Revenue-Based Nominal Amount Standard for All-Payer QP Performance Periods 2021 and later.	***CMS finalized that an Other Payer Arrangement would need to meet either the Benchmark-Based Nominal Amount Standard or the Revenue-Based Nominal Amount Standard (not both)*** (p. 1000). CMS will address the standard for QP Performance Periods after 2020 in future rulemaking (p. 997).
	CMS seeks comment on whether, for Performance Years 2019 and 2020, it should consider a different Revenue-Based Nominal Amount Standard	CMS acknowledged that it received comments supporting a lower financial risk standard for small/rural practices and stated that it will "continue to

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	for small practices and those in rural areas that are not participating in a Medicaid Medical Home Model. CMS also seeks comment on how to define when a practice is "operating in a rural area."	assess the need for a different revenue-based nominal amount standard for small or rural practice organization" but ***declined to set a different standard in the final rule*** (p. 1001).
Other Payer Medical Home Model	**Definition**. In order to align the Other Payer Medical Home Model criteria with arrangements like those in the CPC+ model, CMS seeks comment on whether it should define the term "Other Payer Medical Home Model" as an Other Payer arrangement that is determined by CMS to have the following characteristics: • The other payer arrangement has a primary care focus with participants that primarily include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. (Primary care focus means the inclusion of specific design elements related to eligible clinicians practicing under one more of the following Physician Specialty Codes: 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; and • At least four of the following: ○ Planned coordination of chronic and preventive care ○ Patient access and continuity of care ○ 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 or population-based payments)	CMS stated that because it still has limited information about private payer arrangements, ***CMS believes it should continue to evaluate whether an "Other Payer Medical Home" model is needed*** (p. 992). CMS stated that it might consider the creation of such a definition in future rulemaking.
	Financial Risk. CMS believes it may be appropriate to determine whether an Other Payer Medical Home Model satisfies the financial risk criterion by using special Other Payer Medical Home Model financial risk and nominal amount standards (which could differ from the generally applicable Other Payer Advanced APM standards, but identical to the Medicaid Medical Home Model financial risk and nominal amount standards).	CMS did not make any additional policy changes.
	Additional Information Request. CMS is interested in comments on:	CMS did not make any additional policy changes.

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	• Whether there are payment arrangements that exists that would meet this definition; • Whether such payment arrangements would meet the existing generally applicable Other Payer Advanced APM Financial Risk and Nominal Amount standards; • Whether CMS should consider special circumstances when establishing a definition for a medical home model standard for payers with payment arrangements that would not fit under the Medical Home Model or Medicaid Medical Home Model definitions; ○ How the 50 clinician cap for application of the Medical Home Model financial risk and nominal amount standards apply in these situations.	
Medicaid Medical Home Model	**Financial Risk "Nominal Amount" Standard**. CMS previously finalized that the minimum total annual amount that an APM Entity must potentially owe or forego to be considered an Other Payer Advanced APM/Medicaid Medical Home must be at least: • In 2019, 4% of the APM Entity's total revenue under the payer. • In 2020 and later, 5% of the APM Entity's total revenue under the payer. In response to concerns from stakeholders, CMS proposes revising the standard because it believes a small reduction in risk could allow greater flexibility for Medicaid Medical Home Models CMS proposes that in order for a Medicaid Medical Home to qualify as an Other Payer Advanced APM, the total annual amount that an APM Entity potentially owes or foregoes under the Medicaid Medical Home must be at least: • All-Payer QP Performance Period 2019: 3% of the APM Entity's total revenue under the payer; • All-Payer QP Performance Period 2020: 4% of the APM Entity's total revenue under the payer; • All-Payer QP Performance Period 2021 and later: 5% of the APM Entity's total revenue under the payer.	***CMS finalized its proposal to revise the required amount of risk for Medicaid Medical Homes to qualify as an Other Payer APM.*** CMS clarified (as it did elsewhere in the rule) that it will look at the average total revenues of the participating providers or other entities under the payment arrangement to make the calculations (p. 1004).
Determination of Other Payer Advanced APMs	**General**. CMS previously finalized that eligible clinicians may become QPs if the following steps occur: • The eligible clinician submits to CMS sufficient information on all relevant payment arrangements with other payers; • CMS determines that an Other Payer APM is an Other Payer Advanced APM; and • The eligible clinician meets the relevant QP thresholds by having	

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	sufficient payments or patients attributed to a combination of participation in Advanced APMs and Other Payer Advanced APMs.	
	Payer Initiated Other Payer Advanced APM Determination Process ("Payer Initiated Process"). CMS proposes to allow certain other payers to request that CMS determine whether their Other Payer arrangements are Other Payer Advanced APMs starting prior to the 2019 All-Payer QP Performance Period.	***CMS finalized the creation of the Payer Initiated Process*** (p. 1016). ***CMS finalized that the process would be voluntary*** (p. 1019).
	• These payers for the 2019 All-Payer QP Performance Period include payers with arrangements authorized under Title XIX (Medicaid), Medicare Health Plan payment arrangements (e.g. Medicare Advantage, Medicare-Medicaid Plans, 1876 and 1833 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) plans), and payers with payment arrangements in CMS Multi-Payer Models. CMS proposes to allow remaining other payers (including commercial and other private payers) to request that CMS determine whether Other Payer arrangements are Other Payer Advanced APMs starting in 2019 prior to the 2020 All-Payer QP Performance Period.	***CMS finalized these payer types to submit arrangements prior to the 2019 QP Performance Period*** (p. 1016). ***CMS finalized that Remaining Other Payers would be considered starting in 2019 for the 2020 QP Performance Period*** (p. 1062).
	• CMS proposes that Other Payer Advanced APM determination would be in effect for only one year at a time.	***CMS finalized this policy*** (p. 1019). However, in response to concerns about the burden associated with an annual determination process, CMS stated that, after the first year, it will "evaluate whether there is an appropriate, less burdensome, and administratively feasible way to extend determinations for subsequent years (p. 1018). ***CMS seeks additional comment on what kind of information should be submitted annually to update Other Payer APM determinations*** (p. 1019). For additional details on the finalized policies for the Payer Initiated Process, see Appendix C. The timeline for Other Payer Advanced APM Determinations can be found in Table 42.
	APM Entity or Eligible Clinician Initiated Other Payer Advanced APM Determination Process ("Eligible Clinician Initiated Process"). CMS proposes that APM Entities and Eligible Clinicians would have the opportunity to request a determination for the year whether the payment arrangements are Other Payer Advanced APMs and that the Eligible Clinician Initiated Process could be used to request determination before the beginning of an All-Payer QP Performance Period for other payer arrangements authorized under Title XIX (Medicaid). This process	***CMS finalized this policy*** (p. 1029). CMS committed to try to minimize the burden associated with the Eligible Clinician Initiated Process and stated that, after the first year submission, CMS will evaluate whether there is an "appropriate, less burdensome, and administratively feasible way to extend determinations" beyond a single year (p. 1028). ***CMS is seeking additional comment on the current duration of payment arrangements and whether creating a multi-year determination process could encourage multi-year payment arrangements (as opposed to payment***

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	would not be necessary for Other Payer arrangements that are determined to be Other Payer Advanced APMs under the Payer Initiated Process.	***arrangements that are one year. CMS also seeks comment on what kind of information would need to be submitted annually after the first year to update a determination*** (p. 1029). For additional details on the finalized policies for the Eligible Clinician Initiated Process, see Appendix D. The timeline for Other Payer Advanced APM Determinations can be found in Table 42.
Medicaid APMs and Medicaid Medical Home Models	**"No available Medicaid APM or Medicaid Medical Home Model":** CMS notes that there are differences in the determination process for Other Payer arrangements where Medicaid is the payer and the process for Other Payer arrangements with other types of payers. CMS believes that these differences are necessary because of the MACRA language that directs CMS when making QP determinations under the All-Payer Combination Option to exclude from the calculation of "all other payments" any payments made (or patient count) under Title XIX (Medicaid) in a state where there is no available Medicaid APM or Medicaid Medical Home Model. Therefore, CMS needs to determine which states have no available Medicaid APMs or Medicaid Medical Home Models that meet the Other Payer Advanced APM criteria during a given All-Payer QP Performance Period. CMS proposes that if, for a given state, CMS receives no determination requests for Other Payer arrangements that could be Medicaid APMs or Medicaid Medical Home Models that are Other Payer Advanced APMs for the year through either the Payer Initiated Process or the Eligible Clinicians Initiated Process, CMS would assume there are no Medicaid APMs or Medicaid Medical Home Models that meet the Other Payer Advanced APM criteria in that state for the relevant All-Payer QP Performance Period. CMS would then exclude Title XIX payments and patients from the All-Payer Combination calculations for eligible clinicians in that state.	***CMS finalized this policy as proposed*** (p. 1118).
	County Specificity. CMS also proposes that it will use county level data to determine whether a state operates a Medicaid APM or a Medicaid Medical Home Model at a sub-state level. CMS believes that applying the exclusion at the county level will help them implement the statutory provision in a way that would avoid penalizing Eligible Clinicians who have no Medicaid APMs or Medicaid Medical Home Models available to them.	***CMS finalized this policy as proposed*** (p. 1118).
	CMS proposes that in states where a Medicaid APM or Medicaid Medical Home Model only exists in certain counties, CMS would exclude Title XIX (Medicaid) data from the Eligible Clinician's QP calculations unless the	***CMS finalized this policy as proposed*** (p. 1119).

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	county where the Eligible Clinician saw the most patients during the relevant All-Payer QP Performance Period was a county were a Medicaid APM or Medicaid Medical Home Model determined to be an Other Payer Advanced APM was available. CMS will require Eligible Clinicians to identify and certify the county where they saw the most patients during the relevant All-Payer QP Performance Period.	
	Specialty Specificity. CMS proposes to identify Medicaid APM or Medicaid Medical Home Models that are only open to certain specialties via questions asked of states in the Payer Initiated Process and of APM Entities and Eligible Clinicians in the Eligible Clinician Initiated Process.	***CMS finalized this policy as proposed*** (p. 1120).
CMS Multi-Payer Models	CMS proposes to define "CMS Multi-Payer Models" as an Advanced APM that CMS determines, per the terms of the Advanced APM, has at least one other payer arrangement that is designed to align with the terms of that Advanced APM.	***CMS finalized its proposed definition of CMS Multi-Payer Models*** (p. 1047).
	CMS proposes that beginning in the first All-Payer QP Performance Period payers with other payer arrangements in a CMS Multi-Payer Model may request a determination whether those aligned with Other Payer arrangements are Other Payer Advanced APMs.	***CMS finalized this policy*** (p. 1049).
	CMS proposes that if the payment arrangement in the CMS Multi-Payer arrangement is a payment arrangement authorized under Title XIX (Medicaid) that they rely on the processes laid out for Medicaid arrangements. CMS proposes in these cases that the state would submit on behalf of payers in the Payer Initiated Process for Other Payer Advanced APMs under which the same Payer Initiated Process and rules for CMS Multi-Payer Models would apply.	***CMS received no comments on the proposal and finalized this policy*** (p. 1050).
Medicare Health Plans	These plans include Medicare Advantage, Medicare-Medicaid Plans, 1876 and 1833 Cost Plans, and PACE plans.	
	CMS is exploring whether it can create a mechanism for those who participate in Advanced APMs that include Medicare Advantage to receive credit for that participation under the Medicare Option.	CMS believes there is merit in "testing the effects of incentives for eligible clinicians to participate in alternative payment arrangements with Medicare Advantage." ***CMS is considering potential demonstration project designs that would accomplish this*** (p. 1055).
	CMS proposes that Medicare Health Plans may request a determination on whether their payment arrangement is an Other Payer Advanced APM prior to the All-Payer QP Performance Period by submitting information contemporaneously with the annual bidding process for Medicare Advantage (i.e. the first Monday in June of the year prior to the payment	***CMS finalized this proposal*** (p. 1057).

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	and coverage year).	
Remaining Other Payers	CMS proposes to allow remaining other payers not addressed in the proposals (including other private payers that are not states, Medicare Health Plans or payers with arrangements aligned with a CMS Multi-Payer Model) to request that CMS make a determination on whether Other Payer arrangements are Other Payer Advanced APMs starting prior to the 2020 All-Payer QP Performance Period.	***CMS finalized this proposal*** (p. 1062).
	CMS proposes that APM Entities and Eligible Clinicians can request a determination on whether an Other Payer arrangement is an Other Payer Advanced APM starting prior to the 2020 All-Payer QP Performance Period.	***CMS finalized this proposal*** (p. 1062). CMS stated that it received many comments in opposition to the delay of submissions by Remaining Other Payers until consideration for the 2020 QP Performance Period. However, CMS stated that it opted for a gradual implementation where it will first work with the payers with which they have "significant and long-standing pre-existing relationship" (p. 1061).
Timing of QP Determinations Under the All-Payer Combination Option	CMS proposes to create a separate QP Performance Period for the All-Payer Combination Option: it would begin on January 1 and end on June 30 of the calendar year that is two years prior to the payment year.	***CMS did not finalize the All-Payer Combination Option Performance Period of January 1 – June 30; instead CMS finalized a QP Performance Period (for both the Medicare Option and All-Payer Combination Option) of January 1 – August 31 of the calendar year that is two years prior to the payment year*** (p. 1106). CMS agreed that it was preferable to align the QP Performance Periods for the Medicare Option and All Payer Combination Option. CMS continues to believe however that a QP Performance Period of 12 months would leave it without enough time to make QP determinations and notify Eligible Clinicians of their QP status in advance of the MIPS reporting deadline (p. 1106).
	CMS proposes to make QP determinations based Eligible Clinician participation in Advanced APMs and Other Payer Advanced APMs between January 1 through March 31 and January 1 through June 30 under the All-Payer Combination Option.	***CMS finalized that it will make QP determinations based on three snapshot dates: March 31, June 30, and August 31*** (p. 1107).
	CMS proposes to inform Eligible Clinicians of their QP status under the All-Payer Combination Option as soon as practicable after the proposed All-Payer Information Submission Deadline.	***CMS finalized its proposal to notify Eligible Clinicians of their QP status under the All-Payer Combination Option "as soon as practicable" after the proposed QP Determination Submission Deadline*** (p. 1107).
QP Determinations at the Individual Eligible Clinician Level	CMS proposes to make QP determinations under the All-Payer Combination at the individual Eligible Clinician level only. CMS seeks input on the extent to which APM Entity groups in Advanced APMs could agree to be assessed collectively for performance in Other Payer Advanced APMs and on whether there is variation among Eligible Clinicians within an APM Entity group in their participation in Other Payer arrangements. CMS requests input on whether APM Entities in Other Payer Advanced APMs could report this information at the APM Entity	CMS continues to believe that it will have operational challenges making QP determinations under the All Payer Combination Option at the APM Entity-level, but also understands that QP determinations at the individual Eligible Clinician level could be burdensome. ***CMS finalized a "flexible" policy where an eligible clinician may request a QP determination at the individual Eligible Clinician level and the APM Entity may request a QP determination at the APM Entity level*** (p. 1111). CMS notes that in instances where QP determination requests are made at the APM Entity

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	Group level to facilitate CMS QP determinations at the group level.	level, the composition of the APM Entity will be consistent across Advanced APMs and Other Advanced APMs. If CMS receives determination requests at both levels, CMS will make the determination at both levels (p. 1111). ***CMS is requesting comment on whether it should add a third alternative to provide for QP determinations at the TIN level when all clinicians who have reassigned billing to the TIN are included in a single APM Entity (and potentially better align with existing recordkeeping practices and thereby be less burdensome)*** (p. 1112).
	CMS previously finalized that when an Affiliated Practitioners List defines the Eligible Clinicians to be assessed for QP determination in the Advanced APM, CMS will make the QP determination under the Medicare Option only at the individual level. CMS proposes that, if in response to comments CMS adopts a mechanism to make QP determinations under the All-Payer Combination Option at the APM Entity-level, then eligible clinicians who meet the criteria to be assessed individually under the Medicare Option would still be assessed individually under the All-Payer Combination Option.	***CMS finalized this policy so Eligible Clinicians who are assessed individually under the Medicare Option will be assessed only individually under the All Payer Combination Option*** (p. 1112).
Medicare Payment Amounts and Patient Count Calculations	CMS proposes to use individual Eligible Clinician-level payment amounts and patient counts for the Medicare calculations in the All-Payer Combination Option.	Because CMS finalized a modified version of the proposal to make QP determinations at the individual level, ***CMS finalized a modified version of this proposal*** (p. 1113): When CMS makes QP determinations at the individual level, it will use individual Eligible Clinician level payment amounts and patient counts; when CMS makes QP determinations at the APM Entity Level, it will use APM Entity level payment amounts and patient counts.
	However, Medicare highlights that this methodology could result in scenarios in which an individual Eligible Clinician's Medicare threshold score calculated at the APM Entity group level could be higher than the score based only on assessing Medicare participation at the individual level. To address this issue, CMS proposes a modified methodology that when an Eligible Clinician's threshold score at the individual level is a lower percentage than the one that is calculated at the APM Group level, CMS would apply a weighted methodology.	***CMS finalized the weighted methodology with modification*** (p. 1116): CMS clarifies that it will only use the weighted methodology when QP determinations are made at the individual Eligible Clinician level and when the individual Threshold Scores under the Medicare Option are lower than the APM Entity group Threshold Scores under the Medicare Option (p. 1117). CMS provides an example of this methodology in Table 43.
	Payment Amount Method. CMS proposes that the numerator would be the aggregate of all payments from all payers (except those excluded) attributable to the Eligible Clinician only from either January 1 through	***CMS finalized this policy with the modification that the performance period is now January 1 – August as finalized under other provisions*** (p. 1122).

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	March 31 or January 1 through June 30 of the All-Payer QP Performance Period. CMS proposes that the denominator would be the aggregate of all payments from all payers (except excluded payments) to the Eligible Clinician from either January 1 through March 31 or January 1 through June 30 of the All-Payer QP Performance Period.	
	Patient Count Method. CMS proposes to count each unique patient one time in the numerator and one time in the denominator across all payers, and the numerator would be the number of unique patients the Eligible Clinician furnishes services to under the terms of all their Advanced APMs or Other Payer Advanced APMs from either January 1 through March 31 or January 1 through June 30 of the All-Payer Performance Period. CMS proposes that the denominator would be the number of unique patients the Eligible Clinician furnishes services to under all payers (except those excluded) from either January 1 through March	***CMS did not adopt its proposals.*** Instead, it is retaining previously finalized policies where it would count each unique patient one time in the numerator and one time in the denominator. CMS will also have an August 31st snapshot date because of the finalized performance period (p. 1124).
Submission of Information for QP Determination	**Required Information:** • CMS proposes to collect payment amount and patient count information aggregated for the two proposed snapshot time frames (January 1 – March 31; January 1 – June 30).	***CMS finalized three snapshot dates for both the Medicare Option and All-Payer Combination Option: March 31, June 30, and August 31*** (p. 1127).
	• CMS proposes that all of this payment and patient information must be submitted at the eligible clinician level (not the APM Entity group level as finalized last year).	Because CMS is finalizing a policy where determinations might be made at the individual or APM Entity level, ***CMS finalized a policy that the information must be submitted at either the individual or APM Entity level commensurate with the level of calculation requested*** (p. 1128).
	• CMS proposes to allow Eligible Clinicians to have APM Entities submit this information on behalf of any Eligible Clinicians in the APM Entity group at the individual Eligible Clinician level.	***CMS finalized this proposal*** (p. 1130).
	• CMS proposes that if an APM Entity or Eligible Clinician submits sufficient information for only the payment amount method or patient count method (but not both), CMS will make a QP determination based on the method for which it receives sufficient information.	***CMS finalized this proposal*** (p. 1131).
	• CMS proposes to create and require use of a form that APM Entities and Eligible Clinicians would use to submit payment amount and patient count information.	***CMS finalized this proposal*** (p. 1131).
	Deadline. CMS proposes that APM Entities or Eligible Clinicians must submit all of the required information (including those for which there is a pending request for an Other Payer Advanced APM determination), as	***CMS finalized this proposal*** (p. 1133)

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	well as the payment amount information and patient count information sufficient for CMS to make a QP determination by December 1 of the calendar year that is 2 years prior to the payment year (the "QP Determination Submission Deadline"). **Certification & Program Integrity:** • CMS proposes that the APM Entity or Eligible Clinician that submits information to request a QP determination under the All-Payer Combination Option must certify to the best of its knowledge that the information submitted is true, accurate, and complete; CMS proposes to revise the policy to apply to information submitted to for QP determinations. CMS also proposes to add language stating that an APM Entity or Eligible Clinician who submits information for QP determination must provide information and supporting documentation upon request. • CMS also proposes that, to the extent permitted by federal law, CMS will maintain confidentiality of the information that APM Entities or eligible clinicians submit for purposes of QP determinations under the All-Payer Combination Option, in order to avoid dissemination of potentially sensitive contractual information or trade secrets	***CMS finalized these proposals and reduced the record retention requirement to 6 years from the end of the QP Performance Period or from the date of completion of any audit, evaluation, or inspection whichever is later*** (p. 1135). ***CMS finalized these policies as proposed*** (p. 1136).
Partial QP Election to Report to MIPS	Under the Medicare Option, CMS previously finalized that in cases where the QP determination is made at the individual Eligible Clinician level, if the Eligible Clinician is determined to be a Partial QP, the Eligible Clinician will make the election whether to report to MIPS and be subject to the MIPS reporting requirements and payment adjustments. To promote alignment, CMS proposes that Eligible Clinicians who are Partial QPs for the year under the All-Payer Combination Option would also make the election whether to report to MIPS and be subject to MIPS reporting requirements and payment adjustments.	***CMS finalized this policy as proposed*** (p. 1142).
Physician-Focused Payment Models (PFPMs)		
General	CMS seeks comments on whether it should broaden the definition of PFPM to include payment arrangements that involve Medicaid or the Children's Health Insurance Program (CHIP) as a payer, even if Medicare is not included as a payer. • CMS seeks input on the impact of broadening the definition further given that the Secretary does not have the authority to	CMS did not make an actual proposal to change the definition of a PFPM so could not finalize the inclusion models where Medicaid or CHIP is the only payer (p. 1152). CMS stated it might seek further comment or propose a change of this nature in future rulemaking (p. 1152).

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	direct the design or development of payment arrangements that might be tested with private payers. • CMS seeks comment on whether broadening the definition of PFPMs would inclusive of potential PFPMs that could focus on areas not generally applicable to the Medicare population (e.g. pediatric issues or maternal health). • CMS seeks comment on whether including more issues and populations fits within PTAC's charge. CMS seeks comment on whether it should require that a PFPM be an APM "or a payment arrangement under the legal authority for Medicaid and CHIP payment arrangements." CMS also seeks input on the value of having proposals for PFPMs with Medicaid or CHIP (but not Medicare) as a payer go through PTAC's review process.	CMS stated that it was also concerned about the uncertainties that a change in the PFPM definition could make at PTAC. CMS stated that these types of models would be highlight depending on the role of states in proposed PFPMs. CMS stated that it believed "PTAC can have the greatest impact by focusing on those proposed models where the Secretary has the greatest authority to directly advanced or contribute to the implementation of the proposed model – that is, those that include Medicare FFS as a payer." (p. 1152).
Relationship between PFPMs and Advanced APMs	CMS reiterated its finalized policy that PFPMs need not meet the requirements to be an Advanced APM. CMS notes that it "intends to give serious consideration to proposed PFPMs recommended by the PTAC." While this is the case, CMS reiterated that it is not in a position to commit to test all such models and continues that any PFPMs with Medicaid or CHIP as a payer could not be testing without significant coordination and cooperation with the states in involved. Therefore, the Secretary and CMS retain the ability to make final decisions on which PFPMs are tested, whether they include Medicare as a payer or only include Medicaid and CHIP.	CMS did not propose or finalize any changes and reminded stakeholders that if PFPMs are selected for testing, CMS will determine the appropriate APM status of the PFPM (p. 1154). CMS received requests for a deadline by which the Secretary must respond to PTAC recommendations as well as requests to expedite the PTAC process. CMS replied that it needed varying lengths of time to review, comment on, and respond to PFPM proposals depending on the specifics of each proposal (p. 1156). CMS stated that it would not be appropriate to establish a single process or timeline for PTAC review or for implementation of proposed models, but also stated that CMS was "mindful of stakeholders' interest in a timeline process and are committed to reviewing (and where appropriate, implementing PFPM proposals as quickly as possible." (p. 1157).
PFPM Criteria	CMS seeks comment on the previously finalized PTAC criteria including (but not limited to) whether the criteria are appropriate for evaluating PFPM proposals and are clearly articulated. In addition, CMS seeks comment on stakeholder needs in developing PFPM proposals that meet the Secretary's criteria. In particular, CMS is seeking input on whether stakeholders believe there is sufficient guidance available on: • What constitutes a PFPM; • The relationship between PFPMs, APMs, and Advanced APMs; and • On how to access data or gather supporting evidence for a	CMS made no changes to the criteria. Highlights of the comments received include: • A commenter said that PFPMs should have a "patient centered approach." CMS stated that it believes that this is currently covered in the Integration and Care Coordination and Patient Choice criteria (p. 1159). • CMS received input that the criteria be revised to elevate the value and importance of specialists in PFPMs and that PTAC require submitters to consult affected specialties prior to model submission. CMS stated that the comments were outside the

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	PFPM proposal.	scope of rulemaking but that considerations related to specialty care fall within the existing criteria for Scope, Flexibility, and Integration and Care Coordination (p. 1159). • CMS received a comment that the Payment Methodology criterion should require a neutral party determine and disseminate payments to participants. CMS replied that if it proceeds with implementation of any PFPMs, it will work to address any payment methodology concerns, including conflicts of interest (p. 1160). • CMS received input that the Patient Safety criterion should be assigned as a High Priority criterion. CMS states that it believes the criteria as they currently exist and supplement information allow the PTAC to analyze potential adverse impact to necessary services (p. 1161). CMS received many requests that the agency provide technical assistance to stakeholders developing and submitting models. CMS stated that it is committed to continuing to explore ways to assist stakeholders in developing proposals (including with data support) (p. 1162).

Extreme and Uncontrollable Circumstance Policy for the Transition Year Interim Final Rule with Comment Period

Topic	Final Rule
General	In order to account for Hurricanes Harvey, Irma, and Maria and other disasters that have occurred or might occur during the 2017 MIPS performance period, CMS is establishing through this interim final rule with comment period an *automatic* extreme and uncontrollable circumstance policy for the quality, improvement activities, and advancing care information performance categories for the 2017 MIPS performance period. CMS believes this policy will reduce clinician burden during a catastrophic time and will also align with Medicare policies in other programs such as the Hospital IQR Program. CMS will apply this policy to *individual* MIPS eligible clinicians for the 2017 MIPS performance period without requiring a MIPS eligible clinician to submit an application when it determines a triggering event, such as a hurricane, has occurred and the clinician is in an affected area. CMS will automatically weight the quality, improvement activities, and advancing care information performance categories at 0% of the final score, resulting in a final score equal to the performance threshold due to CMS' policy that a MIPS eligible clinician with fewer than two performance category scores will receive a final score equal to the performance threshold. As such, an individual will receive a final score equal to the performance threshold if they do not submit any data or submit data on only one performance category for the 2017 performance periods. If the individual MIPS eligible clinician submits data on 2 or more performance categories, then the clinician will be scored on their data submissions under the policies that apply to all other MIPS eligible clinicians who are not in affected areas. Note that administrative claims measures are not included in this automatic extreme and uncontrollable circumstance policy since the only administrative claims measure used in 2017 to determine a MIPS final score is the readmission measure, which is only applied to groups (which are excluded from the automatic extreme and uncontrollable circumstance policy). To clarify, although this policy includes individual MIPS eligible clinicians who practice in impacted areas and are part of a group practice, the policy does not apply to groups for the transition year, although CMS may address its application to groups in future rulemaking. In the 2017 QPP final rule (81 FR 77325 through 77329), CMS adopted a policy for redistributing the weights of the performance categories in the final score for the 2017 performance period/2019 MIPS payment year. This policy did not include a scenario where a MIPS eligible clinician would not receive an improvement activities performance category score for 2017. With the addition of the automatic extreme and uncontrollable circumstance policy in this interim final rule with comment period, it is possible for a MIPS eligible clinician not to receive a score for the improvement activities performance category and for the category to be reweighted to 0% in the final score; therefore, CMS needs to modify its existing policy for redistributing the performance category weights for 2017 to account for this situation. Although not adopted for the 2018 performance year, CMS is adopting the following redistribution policy for the 2017 performance year. This policy is the same as the existing policy for the transition year, but also accounts for the scenario where a MIPS eligible clinician has a score for the quality and advancing care information performance categories, but not an improvement activities performance category score. In this case, CMS would redistribute the weight of the improvement activities performance category to the quality performance category. **TABLE 48: Performance Category Redistribution Policies for CY 2017 MIPS Performance Period** | Performance Category	Weighting for the 2019 MIPS Payment Year	Reweight Scenario If No Advancing Care Information Performance Category Score	Reweight Scenario If No Quality Performance Category Percent Score	Reweight Scenario If No Improvement Activities Performance Category Score
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Quality	60%	85%	0%	75%
Cost	0%	0%	0%	0%
Improvement Activities	15%	15%	50%	0%
Advancing Care Information	25%	0%	50%	25%	 CMS will determine if an individual MIPS eligible clinician is in an impacted area based on the practice location address listed in the Provider Enrollment, Chain and Ownership System (PECOS).

CMS anticipates the types of events that could trigger this policy would be events designated a Federal Emergency Management Agency (FEMA) major disasters or a public health emergency declared by the Secretary, although CMS will review each situation on a case-by-case basis. CMS believes that Hurricanes Harvey, Irma, and Maria are such triggering events and lists the affected regions in this rule (p. 1174). CMS notes that these lists may continue to be updated and that the most current list of impacted areas can be found here. Should additional extreme and uncontrollable circumstances arise for the 2017 MIPS performance period that trigger the automatic extreme and uncontrollable circumstance policy, CMS would communicate that information through routine communication channels, including but not limited to issuing memos, e-mails, and notices on the QPP Web Site.

CMS is not modifying the APM scoring standard policies that apply in 2017 for participants in MIPS APMs who have been affected by extreme and uncontrollable circumstances. CMS will continue to apply the quality category scoring methodology for MIPS APMs; the improvement activities performance category will continue to be automatically scored; and the advancing care information category will be scored according to the APM scoring standard, which would include MIPS eligible clinicians in affected areas who qualify for a 0% weighting of the advancing care information performance category under the automatic extreme and uncontrollable circumstance policy adopted in this interim final rule.

CMS is waiving notice and comment and adopting this policy on an interim final basis due to the urgency of providing relief for MIPS eligible clinicians impacted by recent natural disasters during the 2017 MIPS performance period. However, if still welcome feedback on these policies. ***More specifically, CMS invites public comment on:***

- ***Its automatic extreme and uncontrollable circumstance policy for individual MIPS eligible clinicians for the 2017 MIPS performance period.***
- ***Applying the automatic extreme and uncontrollable circumstance policy based on triggering events that affect an entire region or locale, on a case-by-case basis.***
- ***Its proposed policies related to scoring the performance categories.***
- ***Its policy for determining which MIPS eligible clinicians are in affected areas based on practice location addresses listed in PECOS***
- ***How it should apply the automatic extreme and uncontrollable circumstance policies for groups and virtual groups in future years, which might have multiple practice sites (e.g. should it be based on whether a certain percentage of clinicians in the group are located in the affected area)?***

Collection of Information Requirements

Topic	Final Rule
General	In this final rule, CMS continues the slow ramp-up of the QPP by establishing special policies for Year 2 aimed at encouraging successful participation in the program while reducing burden, and preparing clinicians for compliance with the 2019 performance period (2021 payment year) statutory requirements. While CMS acknowledges commenters' concerns that more rigorous requirements for QPP Year 2 may lead to increased data submission burden, it clarifies that its burden estimates in the 2017 QPP final rule accounted for MIPS eligible clinicians choosing the full year participation option in MIPS with complete data submission (as opposed to reporting only the minimum 90 days of data) for the 2017 performance period and, therefore, it did not adjust these estimates for this final rule with comment period. CMS estimates that this final rule will result in approximately $694 million in collection of information-related burden. CMS estimates that the incremental collection of information-related burden associated with this final rule is a reduction of approximately $13.9 million relative to the estimated burden of continuing the policies the CY 2017 Quality Payment Program final rule, which is $708 million. As a comparison, in the 2017 QPP final rule, CMS estimated a reduction of burden costs of $7.4 million relative to the legacy programs (PQRS and EHR Incentive Program for Eligible Professionals) it replaced (81 FR 77513). This reduction in burden reflects CMS' decision to finalize several proposed policies, including a new significant hardship exception for small practices for the advancing care information performance category; using a shorter version of the CAHPS for MIPS survey; and allowing MIPS eligible clinicians to form virtual groups which would create efficiencies in data submission. CMS also anticipates further reduction in burden because of policies set forth in the 2017 QPP final rule, including greater clinician familiarity with the measures and data submission methods set in their second year of participation, operational improvements, and streamlining registration and data submission. A summary of CMS' annual burden estimates can be found in Table 74. With new Advanced APMs expected to be available for participation in 2018, including the Medicare ACO Track 1 Plus (1+) Model, and the addition of new participants for some current Advanced APMs, such as the Next Generation ACO Model and Comprehensive Primary Care Plus (CPC+) Model, CMS anticipates higher numbers of QPs in subsequent years of the program. It currently estimates that approximately 185,000 to 250,000 eligible clinicians may become QPs for payment year 2020 based on Advanced APM participation in performance year 2018. Other information to note includes: Table 51: CMS estimates that approximately 765 MIPS eligible clinicians will decide to join 16 virtual groups for the 2018 MIPS performance period. Table 52: burden estimates related to the QCDR and Qualified Registry self-nomination process. Table 54: estimated counts of clinicians that will submit quality performance category data as MIPS individual clinicians, groups, or virtual groups in the 2018 MIPS performance period (the most frequently used mechanism is estimated to be claims). Table 64: participation estimates for the quality performance category. Table 65: participation estimates for the advancing information performance category. Table 67: participation for the improvement activities performance category.

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Change in Medicare Payments		
Estimated Incentive Payments to QPs in Advanced APMs	CMS estimates that between 180,000 and 245,000 eligible clinicians will become QPs, therefore be exempt from MIPS, and qualify for lump sum incentive payment based on 5% of their Part B allowable charges for covered professional services, which are estimated to be between approximately $11,820 million and $15,770 million in the 2018 Quality Payment Program performance year. Further, the aggregate total of the APM incentive payment of 5% of Part B allowed charges for QPs would be between approximately $590 and $800 million for the 2020 Quality Payment Program payment year.	***CMS estimates that between 185,000 and 250,000 eligible clinicians will become QPs, therefore be exempt from MIPS, and qualify for lump sum incentive payment based on 5% of their Part B allowable charges for covered professional services, which are estimated to be between approximately $13,500 million and $18,000 million in the 2018 Quality Payment Program performance year***. Further, the aggregate total of the APM incentive payment of 5% of Part B allowed charges for QPs would be between approximately $675 and $900 million for the 2020 Quality Payment Program payment year. (p. 1269)
Estimated Number of Clinicians Eligible for MIPS	CMS provides estimates for the projected number of clinicians' ineligible for or excluded from MIPS in 2018, by reason, in Table 85. CMS estimates that 65% of clinicians' $124,029 million in allowed Medicare Part B charges will be included in MIPS, and that approximately 37% of 1,548,022 Medicare clinicians billing to Part B will be included in MIPS. Table 85 also shows the number of eligible clinicians remaining in the scoring model used for this regulatory impact analysis (554,846) is lower than the estimated number of eligible clinicians remaining after exclusions (572,299). The discrepancy is due to CMS' scoring model excluding clinicians that submitted via measures groups under the 2015 PQRS, since that data submission mechanism was eliminated under MIPS.	CMS provides estimates for the projected number of clinicians' ineligible for or excluded from MIPS in 2018, by reason, in Table 75. CMS estimates that 66% of clinicians' $124,029 million in allowed Medicare Part B charges (physician fee schedule services, certain Part B drugs, and other non-physician fee schedule services) will be included in MIPS. Further, ***CMS estimates that approximately 40 percent of 1,548,022 Medicare clinicians billing to Part B will be included in MIPS.*** (p. 1273) Table 75 also shows the number of eligible clinicians remaining in the scoring model used for this RIA (604,006) is lower than the estimated number of eligible clinicians remaining after exclusions (621,700). The discrepancy is due to CMS' scoring model excluding clinicians that submitted via measures groups under the 2016 PQRS, since that data submission mechanism was eliminated under MIPS.
Estimated Impacts on Payments to MIPS Eligible Clinicians	Payment impacts in this proposed rule reflect averages by specialty and practice size based on Medicare utilization. The first analysis, labeled as "standard participation assumptions," relies on the assumption that a minimum 90% of MIPS eligible clinicians will participate in submitting quality performance category data to MIPS, regardless of practice size. CMS assumed that, on average, the categories of practices with 1-15 clinicians would have 90% participation in the quality performance category. This assumption is an increase from existing historical data. Table 86 summarizes the impact on Part B services of MIPS eligible clinicians by specialty for the standard participation assumptions.	Payment impacts in this final rule with comment period reflect averages by specialty and practice size based on Medicare utilization. The first analysis, which CMS labeled as "standard participation assumptions," relies on the assumption that a minimum 90% of MIPS eligible clinicians will participate in submitting quality performance category data to MIPS, regardless of practice size. CMS assumed that, on average, the categories of practices with 1 to 15 clinicians would have 90% participation in the quality performance category. ***Table 76 summarizes the impact on Part B paid amount (physician fee schedule services, certain Part B drugs, and other non-physician fee schedule services) of MIPS eligible clinicians by specialty for the standard participation assumptions.*** (p. 1285)

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	The second analysis, labeled as "alternative participation assumptions," assumes a minimum participation rate in the quality and improvement activities performance categories of 80%. Because the 2015 PQRS participation rates for practices of more than 15 clinicians are greater than 80%, this analysis assumes increased participation for practices of 1-15 clinicians only. Practices of more than 15 clinicians are included in the model at their historic participation rates. Table 87 summarizes the impact on Part B services of MIPS eligible clinicians by specialty under the alternative participation assumptions. Tables 88 and 89 summarize the impact on Part B services of MIPS eligible clinicians by practice size for the standard participation assumptions and the alternative participation assumptions. Table 88 shows that under CMS' standard participation assumptions, the vast majority (96.1%) of MIPS eligible clinicians are anticipated to receive positive or neutral payment adjustments for the 2020 MIPS payment year, with only 3.9% receiving negative MIPS payment adjustments. Using the alternative participation assumptions, Table 89 shows that 94.3% of MIPS eligible clinicians are expected to receive positive or neutral payment adjustments.	The second analysis, labeled as "alternative participation assumptions," assumes a minimum participation rate in the quality performance category of 80%. In the CY 2018 QPP proposed rule [82 FR 30237], CMS used 2015 PQRS data and in this final rule with comment period CMS updated it with 2016 PQRS data. Because both the 2015 and 2016 PQRS participation rates for practices of more than 15 clinicians are greater than 80%, this analysis assumes increased participation for practices of 1 to 15 clinicians only. ***Table 77 summarizes the impact on Part B paid amount (physician fee schedule services, certain Part B drugs, and other non-physician fee schedule services) of MIPS eligible clinicians by specialty under the alternative participation assumptions.*** (p. 1285) Tables 78 and 79 summarize the impact on Part B paid amount (physician fee schedule services, certain Part B drugs, and other non-physician fee schedule services) of MIPS eligible clinicians by practice size for the standard participation assumptions (Table 78) and the alternative participation assumptions (Table 79). (p. 1285) ***Tables 76 and 78 show that under CMS' standard participation assumptions, the vast majority (97.%) of MIPS eligible clinicians are anticipated to receive positive or neutral MIPS payment adjustments for the 2020 MIPS payment year, with only 2.9% receiving negative MIPS payment adjustments. Using the alternative participation assumptions, Tables 77 and 79 shows that 95.3 percent of MIPS eligible clinicians are expected to receive positive or neutral payment adjustments.*** (p. 1285)
Potential Costs of Advancing Care Information and Improvement Activities for Eligible Clinicians	CMS requests comments that provide information that would enable the agency to quantify the costs, costs savings, and benefits associated with implementation and compliance with the requirements of the ACI performance category.	Given public comments, on the cost of compliance with the advancing care information category, ***CMS is not quantifying the costs, costs savings, and benefits associated with implementation and compliance with the requirements of the ACI performance category***. However, given that approximately 40,000 clinicians would no longer be eligible due to the low-volume threshold and approximately 60,000 MIPS eligible clinicians in small practices qualify for a significant hardship exception, CMS believes the overall potential cost of compliance would decrease as a result of the final rule. (p. 1301)
	CMS requests comments that provide information that would enable the agency to quantify the costs, costs savings, and benefits associated implementation of improvement activities.	CMS will take into consideration public comments received regarding the costs of implementation of improvement activities. ***CMS is not quantifying the costs, costs savings, and benefits associated with implementation and compliance with the requirements of the information activities performance category because it cannot systematically determine the amount associated with the regulation compliance at this time***. However, with the reduction in clinicians that are required to submit data to the improvement activities performance

Topic	Proposed Rule	Final Rule
		category due to changes in the low-volume threshold, CMS believes the overall potential cost of compliance would decrease as a result of the final rule. (p. 1305)
Regulatory Review Costs		
General	CMS welcomes any public comments on the approach in estimating the number of entities that will review this proposed rule. CMS also assumes that each reviewer reads approximately 50% of the proposed rule, and seeks public comments on this assumption.	CMS did not receive any specific comments related to the number of readers of this proposed rule, or that each reviewer reads approximately 50 percent of the information. (p. 1314)

APPENDIX A: 2018 ACI Objectives and Measures with Proposed Modifications and Exclusions

2018 ACI Objective	Objective Details	2018 ACI Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion
Protect Patient Health Information	Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.	Security Risk Analysis	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by CEHRT in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process.	No change	No change	No exclusion
Electronic Prescribing	Generate and transmit permissible prescriptions electronically.	e-Prescribing	At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT. Denominator: Number of prescriptions written for drugs requiring a prescription to be dispensed other than controlled substances during the performance period; or number of prescriptions written for drugs requiring a prescription to be dispensed during the performance period. Numerator: The number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.	No change	No change	**Finalized exclusion:** *Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.*
Patient Electronic Access	The MIPS eligible clinician provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific	Provide Patient Access	For at least one unique patient seen by the MIPS eligible clinician: (1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and (2) The MIPS eligible clinician ensures the patient's health information is available for the patient	No change	***CMS finalized its proposal, which begins with the 2018 performance period, to define "timely" as within 4 business days of the information being available to the MIPS eligible clinician. This definition of timely is the same as CMS adopted under the EHR***	No exclusion

2018 ACI Objective	Objective Details	2018 ACI Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion
	education.		(or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programing Interface (API) in the MIPS eligible clinician's CEHRT. Denominator: The number of unique patients seen by the MIPS eligible clinician during the performance period. Numerator: The number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured meet the technical specifications of the API in the MIPS eligible clinician's CEHRT.		***Incentive Programs.***	
		Patient-Specific Education	The MIPS eligible clinician must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to at least one unique patient seen by the MIPS eligible clinician. Denominator: The number of unique patients seen by the MIPS eligible clinician during the performance period. Numerator: The number of patients in the denominator who were provided electronic access to patient-specific educational resources using clinically relevant information identified from CEHRT during the performance period.		No change	No exclusion
Coordination of Care Through Patient	Use CEHRT to engage with patients or their authorized	View, Download, or Transmit	During the performance period, at least one unique patient (or patient-authorized representatives) seen by the MIPS eligible clinician actively		**Finalized change to the measure:** *During the performance period,*	No exclusion

2018 ACI Objective	Objective Details	2018 ACI Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion
Engagement	representatives about the patient's care.		engages with the EHR made accessible by the MIPS eligible clinician. A MIPS eligible clinician may meet the measure by either (1) view, download or transmit to a third party their health information; or (2) access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the MIPS eligible clinician's CEHRT; or (3) a combination of (1) and (2). Denominator: Number of unique patients seen by the MIPS eligible clinician during the performance period. Numerator: The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the performance period and the number of unique patients (or their authorized representatives) in the denominator who have accessed their health information through the use of an API during the performance period.		*at least one unique patient (or patient-authorized representatives) seen by the MIPS eligible clinician actively engages with the EHR made accessible by the MIPS eligible clinician by either (1) viewing, downloading or transmitting to a third party their health information; or (2) accessing their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the MIPS eligible clinician's CEHRT; or (3) a combination of (1) and (2).* ***CMS finalized this change as proposed because CMS erroneously described the actions in the measure (viewing, downloading or transmitting; or accessing through an API) as being taken by the MIPS eligible clinician rather than the patient or the patient-authorized representatives. This change aligns the measure description with the requirements of the numerator and denominator. The change is effective with the performance period in 2017.***	
		Secure Messaging	For at least one unique patient seen by the MIPS eligible clinician during the performance period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative).	No change	No change	No exclusion

2018 ACI Objective	Objective Details	2018 ACI Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion
			Denominator: Number of unique patients seen by the MIPS eligible clinician during the performance period. Numerator: The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative) or in response to a secure message sent by the patient (or patient-authorized representative), during the performance period.			
		Patient-Generated Health Data	Patient-generated health data or data from a non-clinical setting is incorporated into the CEHRT for at least one unique patient seen by the MIPS eligible clinician during the performance period. Denominator: Number of unique patients seen by the MIPS eligible clinician during the performance period. Numerator: The number of patients in the denominator for whom data from non- clinical settings, which may include patient-generated health data, is captured through the CEHRT into the patient record during the performance period.	No change	No change	No exclusion
Health Information Exchange	The MIPS eligible clinician provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral	Send a Summary of Care	For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care clinician (1) creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record. Denominator: Number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the	**Finalized change to the objective:** *The MIPS eligible clinician provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other health care providers into their EHR*	**Finalized change to the measure:** *For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider (1) creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.*	**Finalized exclusion:** *Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.*

2018 ACI Objective	Objective Details	2018 ACI Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion
	or upon the first patient encounter with a new patient, and incorporates summary of care information from other health care clinician into their EHR using the functions of CEHRT.		transferring or referring clinician. Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.	*using the functions of CEHRT.* ***CMS inadvertently used the term "health care clinician" and proposes to replace it with the more appropriate term "health care provider". CMS finalized this change, which applies beginning with the performance period in 2017.***	***CMS inadvertently used the term "health care clinician" and proposes to replace it with the more appropriate term "health care provider". CMS finalized this change, which applies beginning with the 2017 performance period.***	
		Request/Accept Summary of Care	For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician receives or retrieves and incorporates into the patient's record an electronic summary of care document. Denominator: Number of patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available. Numerator: Number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the clinician into the CEHRT.		No change	**Finalized exclusion:** *Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period.*
		Clinical Information Reconciliation	Clinical Information Reconciliation Measure: For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician performs clinical information reconciliation. The MIPS eligible clinician must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient's medication, including the		No change	No exclusion

2018 ACI Objective	Objective Details	2018 ACI Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion
			name, dosage, frequency, and route of each medication; (2) Medication allergy. Review of the patient's known medication allergies; (3) Current Problem list. Review of the patient's current and active diagnoses. Denominator: Number of transitions of care or referrals during the performance period for which the MIPS eligible clinician was the recipient of the transition or referral or has never before encountered the patient. Numerator: The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: Medication list; medication allergy list; and current problem list.			
Public Health and Clinical Data Registry Reporting	The MIPS eligible clinician is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.	Immunization Registry Reporting	The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS)[2].	No change	No change	No exclusion
		Syndromic Surveillance Reporting	The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data from a non- urgent care ambulatory setting where the jurisdiction accepts syndromic data from such settings and the standards are clearly defined.		**Finalized change to the measure:** *The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.* ***CMS originally proposed this***	No exclusion

[2] CMS notes that the functionality to be bi-directional is part of EHR technology certified to the 2015 Edition. It means that in addition to sending the immunization record to the immunization registry, the CEHRT must be able to receive and display a consolidated immunization history and forecast.

2018 ACI Objective	Objective Details	2018 ACI Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion
					change because it inadvertently finalized the measure description that it had proposed for Stage 3 of the EHR Incentive Program and not the measure description that it finalized. However, CMS modified the change so that it does align with the measure description finalized for Stage 3 by adding the phrase "from an urgent care setting" to the end of the measure description. The above reflect the finalized language.	
		Electronic Case Reporting	The MIPS eligible clinician is in active engagement with a public health agency to electronically submit case reporting of reportable conditions.		No change	No exclusion
		Public Health Registry Reporting	The MIPS eligible clinician is in active engagement with a public health agency to submit data to public health registries.		No change	No exclusion
		Clinical Data Registry Reporting	The MIPS eligible clinician is in active engagement to submit data to a clinical data registry.		No change	No exclusion

APPENDIX B: 2018 ACI Transition Objectives and Measures with Finalized Modifications and Exclusions

2018 ACI Transition Objective	Objective Details	2018 ACI Transition Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion
Protect Patient Health Information	Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.	Security Risk Analysis	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by CEHRT in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process.	No change	No change	No exclusion
Electronic Prescribing	MIPS eligible clinicians must generate and transmit permissible prescriptions electronically.	e-Prescribing	At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT. Denominator: Number of prescriptions written for drugs requiring a prescription to be dispensed other than controlled substances during the performance period; or number of prescriptions written for drugs requiring a prescription to be dispensed during the performance period. Numerator: The number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.	No change	No change	**Finalized exclusion:** *Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.*
Patient Electronic Access	The MIPS eligible clinician provides patients (or patient-authorized representative) with timely electronic access to their health information	Provide Patient Access	At least one patient seen by the MIPS eligible clinician during the performance period is provided timely access to view online, download, and transmit to a third party their health information subject to the MIPS eligible clinician's discretion to withhold certain information.	***CMS finalized its proposal to modify this objective beginning with the 2017 performance period by removing the word "electronic" from the description of timely access as it was erroneously included in the final rule (81 FR 77228). It was CMS' intention to***	No change	No exclusion

2018 ACI Transition Objective	Objective Details	2018 ACI Transition Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion
	and patient-specific education.		Denominator: The number of unique patients seen by the MIPS eligible clinician during the performance period. Numerator: The number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party.	***align the objective with the objectives for Patient Specific Education and Patient Electronic Access adopted under modified Stage 2 in the 2015 EHR Incentive Programs final rule, which do not include the word "electronic". The word "electronic" was also not included in the certification specifications for the 2014 Edition, §170.314(a)(15) (Patient-specific education resources) and §170.314(e)(1) (View, download, and transmit to third party).***		
		View, Download, Transmit (VDT)	At least one patient seen by the MIPS eligible clinician during the performance period (or patient-authorized representative) views, downloads or transmits their health information to a third party during the performance period. Denominator: Number of unique patients seen by the MIPS eligible clinician during the performance period. Numerator: The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the performance period.		No change	No exclusion
Secure Messaging	Use CEHRT to engage with patients or their authorized representatives about the patient's care.	Secure Messaging	For at least one patient seen by the MIPS eligible clinician during the performance period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient authorized representative) during the performance period.	No change	No change	No exclusion

2018 ACI Transition Objective	Objective Details	2018 ACI Transition Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion
			Denominator: Number of unique patients seen by the MIPS eligible clinician during the performance period. Numerator: The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative) or in response to a secure message sent by the patient (or patient-authorized representative), during the performance period.			
Health Information Exchange	The MIPS eligible clinician provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other health care clinicians into their EHR using the functions of CEHRT.	Health Information Exchange	The MIPS eligible clinician that transitions or refers their patient to another setting of care or health care clinician (1) uses CEHRT to create a summary of care record; and (2) electronically transmits such summary to a receiving health care clinician for at least one transition of care or referral. Denominator: Number of transitions of care and referrals during the performance period for which the EP was the transferring or referring health care clinician. Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.	**Finalized change to the objective:** *The MIPS eligible clinician provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other health care providers into their EHR using the functions of CEHRT.* ***CMS inadvertently used the term "health care clinician" and finalized its proposal to replace it with the more appropriate term "health care provider" beginning with the performance period in 2017.***	**Finalized change to the measure:** *The MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider (1) uses CEHRT to create a summary of care record; and (2) electronically transmits such summary to a receiving health care provider for at least one transition of care or referral.* ***This change reflects the change finalized for the Health Information Exchange objective which replaced "health care clinician" with "health care provider" and applies beginning with the performance period in 2017.*** **Finalized Change to the denominator:** *Number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the transferring or referring health care provider.*	**Finalized exclusion:** *Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.*

2018 ACI Transition Objective	Objective Details	2018 ACI Transition Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion
					This change reflects the change finalized for the Health Information Exchange Measure which replaced "health care clinician" with "health care provider". CMS also inadvertently referred to the EP in the description and are replacing "EP" with "MIPS eligible clinician". CMS finalized this change, which applies beginning with the performance period in 2017.	
Medication Reconciliation	N/A	Medication Reconciliation	The MIPS eligible clinician performs medication reconciliation for at least one transition of care in which the patient is transitioned into the care of the MIPS eligible clinician. Denominator: Number of transitions of care or referrals during the performance period for which the MIPS eligible clinician was the recipient of the transition or referral or has never before encountered the patient. Numerator: The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: medication list, medication allergy list, and current problem list.	**Finalized objective:** *The MIPS eligible clinician who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.* ***CMS finalized its proposal to add a description of the Medication Reconciliation Objective beginning with the 2017 performance period, which it inadvertently omitted from the 2017 QPP proposed and final rules. This description aligns with the objective adopted for Modified Stage 2 at 80 FR 62811.***	**Finalized Modification to the Numerator:** *The number of transitions of care or referrals in the denominator where medication reconciliation was performed.* ***CMS finalized its proposal to modify the numerator by removing medication list, medication allergy list, and current problem list. These three criteria were adopted for Stage 3, but not for Modified Stage 2. The changes applies beginning with the performance period in 2017.***	No exclusion
Public Health Reporting	The MIPS eligible clinician is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except	Immunization Registry Reporting	The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data.	No change	No change	No exclusion
		Syndromic Surveillance Reporting	The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data.		No change	No exclusion
		Specialized Registry	The MIPS eligible clinician is in active		No change	No exclusion

2018 ACI Transition Objective	Objective Details	2018 ACI Transition Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion
	where prohibited, and in accordance with applicable law and practice.	Reporting	engagement to submit data to a specialized registry.			

APPENDIX C: Other Payer APM Determinations: Payer Initiated Process

	Payer Initiated Process
Guidance and Submission Form	CMS will make guidance available regarding the Payer Initiated Process for each payer type prior to the first Submission Period (2018). CMS will develop a submission form (the "Payer Initiated Submission Form") to request determinations. CMS will make the form available to payers prior to the first Submission Period. ***CMS finalized that will require Payers to use the Payer Initiated Submission Form to request an Other Payer Advanced APM determination*** (p. 1021). CMS noted that CMS states that the Payer Initiated Submission Form will include both questions that are applicable to all payment arrangements and some specific to a particular type of payment arrangement. ***CMS finalized that it will make separate determinations for each Other Payer Arrangement*** (p. 1022). CMS will allow for attachment of supporting documentation. ***CMS clarified that if a payer has the same payment arrangement in place across multiple plans (or multiple payer types) that the payer is allowed to submit one Payer Initiated Submission Form for a determination that will apply to all of those plans or payer types*** (p. 1017). This clarification, however, does not apply to Medicare Health Plans because of operational changes that would be necessary to the Health Plan Management System (HPMS). Medicaid: CMS will work with states as they prepare and submit Payer Initiated Submission Forms. In completing the Payer Initiated Submission Form, states could refer to information already in CMS possession on their payment arrangements to support their request for a determination. This information could include, for example, submissions that states typically make for authorization to modify their Medicaid payment arrangements, such as a State Plan Amendment or an 1115 demonstration's waiver application, Special Terms and Conditions document, implementation protocol document, or other document describing the 1115 demonstration arrangements approved by CMS. ***CMS also finalized that states can request determinations for both Medicaid fee-for-service and Medicaid managed care plan payment arrangements*** (p. 1041). CMS also stated that intends to implement ongoing assistance through existing conversations or negotiations as states design and develop new payment arrangements that may be identified as Other Payer Advanced APMs (p. 1041). Medicare Health Plans: CMS will make guidance available for Medicare Health Plan payment arrangements prior to the first Submission Period (2018). CMS notes that for Medicare Health Plans, the Payer Initiated Submission form will be incorporated into the Health Plan Management System (HPMS) (p. 1057).
Submission Form Content	***CMS finalized that it will require that payers submit the following information for each other payer arrangement*** (p. 1071): • Arrangement name; • Brief description of the nature of the arrangement; • Term of the arrangement (anticipated start and end dates); • Participant eligibility criteria; • Locations (nationwide, state, or county) where this other payer arrangement will be available; • Evidence that the CEHRT criterion is satisfied[3]; • Evidence that the quality measure criterion is satisfied (including an outcome measure); • Evidence that the financial risk criterion is satisfied; and • Other documentation as may be necessary for CMS to determine that the other payer arrangement is an Other Payer Advanced APM (e.g. contracts and other relevant documents that govern the Other Payer arrangement that verify each required information element, copies of full contracts governing the arrangement, or some other documents that detail and govern the payment arrangement).

[3] ***CMS finalized that it would presume that an Other Payer arrangement would satisfy the 50 percent CEHRT use criterion if CMS receives information and documentation from the Eligible Clinician as part of the Eligible Clinician Initiated Process (described below) show that the Other Payer arrangement requires the requesting Eligible Clinician to use CEHRT to document and communicate clinical information*** (p. 1087).

Payer Initiated Process	
	CMS finalized that a submission for an Other Payer Advanced APM determination is complete only if all of these elements are submitted (p. 1071)**.** ***CMS seeks additional comment on the duration of the agreements for Other Payer Arrangements that can be submitted for determination and how frequently portions of those arrangements that are relevant to Other Payer Advanced APM determination may change*** (p. 1071)**.** ***CMS is also seeking comment on whether it should allow for determinations that would be for multiple years and what information would need to be submitted to support that multiple year determination*** (p. 1071)**.**
Submission Period	***CMS finalized that the Submission Period opening date and Submission Deadline would vary by payer type to align with existing CMS processes for payment arrangements authorized under Title XIX, Medicare Health Plan payment arrangements, and payers with payment arrangements in CMS Multi-Payer Models to the extent possible and appropriate*** (p. 1024). Medicaid: ***CMS finalized that the Submission Period for the Payer Initiated Process for use by states to request Other Payer Advanced APM determinations for other payer arrangements authorized under Title XIX will open on January 1 of the calendar year prior to the relevant All-Payer QP Performance Period for which CMS would make the determination for a Medicaid APM or a Medicaid Medical Home Model that is an Other Payer Advanced APM*** (p. 1042). ***CMS also finalized that the Submission Deadline for these submissions is April 1 of the year prior to the All-Payer QP Performance Period for which CMS is making the determination*** (p. 1042). CMS Multi-Payer Models: ***CMS finalized that the submission period would open on January 1 of the calendar year prior to the relevant All-Payer QP Performance Period*** (p. 1050)***. CMS the submission deadline: CMS inadvertently proposed that the submission period would close on June 30 of the calendar year prior to the relevant All-Payer QP Performance Period, but finalized that it should by June 1 of the calendar year prior to the relevant QP Performance Period*** (p. 1050). Medicare Health Plans: ***CMS finalized that the Submission Period would begin and end at the same time as the annual bid timeframe***. The Submission Period would begin when the bid packages are sent out to plans in April of the year prior to the relevant All-Payer QP Performance Period. CMS proposes that the Submission Deadline would be the annual bid deadline, which would be the first Monday in June in the year prior to the relevant All-Payer QP Performance Period (p. 1058).
CMS Determination	Upon the timely receipt of a Payer Initiated Submission Form, CMS would use the information submitted to determine whether the Other Payer arrangement meets the Other Payer Advanced APM criteria. ***CMS finalized that if it determines that the payer has submitted incomplete or inadequate information, CMS would inform the payer and allow the payer to submit additional information, although CMS extended the amount of time allowed for a reply from 10 business days to 15 business days from the date informed*** (p. 1025). For each other payer arrangement for which the payer does not submit sufficient information, CMS would not make a determination in response to that request. ***These determinations are final and not subject to reconsideration.*** Medicaid: ***CMS finalized that if it determine that the state has submitted incomplete or inadequate information, CMS would inform the state and allow the state to submit additional information no later than 15 business days from the date the state is informed*** (p. 1026). For each other payer arrangement for which the state does not submit sufficient information, CMS would not make a determination in response to that request submitted via the Payer Initiated Submission Form. ***These determinations are final and not subject to reconsideration***. CMS Multi-Payer Models: CMS makes parallel proposals for CMS Multi-Payer Models (p. 1026). Medicare Health Plans: CMS finalized parallel proposals for Medicare Health Plans (p. 1026).
CMS	CMS will notify payers of determinations for each request as soon as practicable after the relevant Submission Deadline.

Payer Initiated Process	
Notification	CMS also states that APM Entities or eligible clinicians may submit information regarding an Other Payer arrangement for a subsequent All-Payer QP Performance Period even if CMS has determined that the Other Payer arrangement is not an Other Payer Advanced APM for a prior year. The provisions similarly apply to states submitting information on Medicaid APMs and Medicaid Medical Home Models (p. 1044), CMS Multi-Payer Models (p. 1051), and Medicare Health Plans (p. 1058).
CMS Posting of Other Payer Advanced APMs	CMS stated that it continues to intend to post on the CMS Website a list (the "Other Payer Advanced APM List") of all other payer arrangements that CMS determines to be Other Payer Advanced APMs Prior to the start of the relevant All-Payer QP Performance Period (p. 1027). After the All-Payer QP Performance Period, CMS will update the list to include Other Payer Advanced APMs based on requests through the "Eligible Clinician Initiated Process." ***CMS finalized its plan to post, on a CMS Web site, only the following information about Other Payer arrangements that are determined to be Other Payer Advanced APMs*** (p. 1084): • The names of payers with Other Payer Advanced APMs (as specified in the submission form); • The location(s) in which the Other Payer Advanced APMs are available (whether at the nationwide, state, or county level); and • The names of the specific Other Payer Advanced APMs. CMS previously finalized that, to the extent permitted by Federal law, CMS would maintain confidentiality of certain information that APM Entities or eligible clinicians submit for purposes of Other Payer Advanced APM determinations to avoid dissemination of potentially sensitive contractual information or trade secrets. ***CMS also finalized that, with the exception of the specific information proposed for posting above, the information a payer submits through the Payer Initiated Process would be kept confidential to the extent permitted by Federal law, in order to avoid dissemination of potentially sensitive contractual information or trade secrets*** (p. 1084). CMS noted that records that the submitter marks as confidential will be protected from disclosure under FOIA Exemption 4 (p. 1082).
Certification and Program Integrity	***CMS finalized a requirement that a payer that submits information must certify to the best of its knowledge that the information it submitted is true, accurate, and complete and that this certification must accompany the Payer Initiated Submission Form and any supporting documentation that payers submit to us through this process*** (p. 1076)**.** ***CMS also finalized the following monitoring and program integrity provisions***: • CMS proposes to specify that information submitted by payers for purposes of the All-Payer Combination Option may be subject to audit. The purpose of any such audit would be to verify the accuracy of an Other Payer Advanced APM determination. (CMS seeks comment on how this might be done with minimal burden to payers.) • CMS proposes to require payers who choose to submit information through the Payer Initiated Process to provide such books, contracts, records, documents, and other evidence as necessary to audit an Other Payer Advanced APM determination. • CMS proposes that such information and supporting documentation must be provided upon request. CMS had also proposed CMS proposes that information must be maintained for 10 years after submission. ***CMS finalized a modified record retention policy of 6 years after submission*** to address concerns about the burden associated with maintaining information (p. 1075).

APPENDIX D: Other Payer APM Determinations: Eligible Clinician Initiated Process

Eligible Clinician Initiated Process	
Guidance and Submission Form	CMS will make guidance available regarding the Eligible Clinician Initiated Process for each payer type prior to the first Submission Period (2018). CMS will develop a submission form (the "Eligible Clinician Initiated Submission Form") that would be used by APM Entities or eligible clinicians to request Other Payer Advanced APM determinations. CMS will make this form available to APM Entities and eligible clinicians prior to the first Submission Period. CMS propose that APM Entities and eligible clinicians would be required to use the Form to request a determination (p. 1029; p. 1030). ***CMS clarified that only APM Entities or Eligible Clinicians that hold contracts with an Other Payer should submit an Eligible Clinician Initiated Submission Form*** (p. 1030). CMS states that the form will include questions that are applicable to all other payer arrangements and some that are specific to a particular type of other payer arrangements. CMS will include a way for APM Entities or eligible clinicians to attach supporting documentation. ***CMS finalized that APM Entities or eligible clinicians may submit requests for review of multiple other payer arrangements through the Eligible Clinician Initiated Process*** (p. 1030). CMS will make separate determinations as to each other payer arrangement. An APM Entity or eligible clinician would be required to use a separate Eligible Clinician Initiated Submission Form for each other payer arrangement. Medicaid: ***CMS finalized that APM Entities and Eligible Clinicians may request determinations for any Medicaid payment arrangement in which they are participating prior to the relevant QP Performance Period*** (p. 1045). CMS will make guidance available regarding the Eligible Clinician Initiated Process for payment arrangements authorized under Title XIX prior to the first Submission Period (2018) (p. 1029).
Submission Form Content	***CMS its requirement that APM Entities or eligible clinicians submit the following information for each other payer arrangement*** (p. 1072): • Arrangement name; • Brief description of the nature of the arrangement; • Term of the arrangement (anticipated start and end dates); • Participant eligibility criteria; • Locations (nationwide, state, or county) where this other payer arrangement will be available; • Evidence that the CEHRT criterion is satisfied[4]; • Evidence that the quality measure criterion is satisfied (including an outcome measure); • Evidence that the financial risk criterion is satisfied; and • Other documentation as may be necessary for CMS to determine that the other payer arrangement is an Other Payer Advanced APM (e.g. contracts and other relevant documents that govern the Other Payer arrangement that verify each required information element, copies of full contracts governing the arrangement, or some other documents that detail and govern the payment arrangement). ***CMS requires that a submission for an Other Payer Advanced APM determination is complete only if all of these elements are submitted*** (p. 1072)**.**
Submission Period	***CMS finalized that APM Entities or eligible clinicians may request Other Payer Advanced APM determinations beginning on August 1 of the same year as the relevant All-Payer QP Performance Period*** (p. 1032). ***CMS finalized that the Submission Deadline for requesting Other Payer Advanced APM determinations (as well as to request QP determinations under the All-Payer Combination Option) is December 1 of the same year as the relevant All-Payer QP Performance Period*** (p. 1033)**.** Medicaid: ***CMS finalized that APM Entities or Eligible Clinicians may submit Eligible Clinician Initiated Forms for payment arrangements authorized under***

[4] ***CMS finalized that it would presume that an Other Payer arrangement would satisfy the 50 percent CEHRT use criterion if CMS receives information and documentation from the Eligible Clinician as part of the Eligible Clinician Initiated Process (described below) show that the Other Payer arrangement requires the requesting Eligible Clinician to use CEHRT to document and communicate clinical information*** (p. 1087).

Eligible Clinician Initiated Process	
	Title XIX prior to the All-Payer QP Performance Period (beginning in 2018) (p. 1033)***. CMS proposes that the Submission Deadline is December 1 of the calendar year prior to the All-Payer QP Performance Period*** (p. 1033).CMS clarified that Medicaid is the only category of payment arrangements where APM Entities or Eligible Clinicians must submit information prior to the performance period is for Medicaid payment arrangements (p. 1032). CMS Multi-Payer Models: ***CMS finalized that APM Entities or eligible clinicians may request Other Payer Advanced APM determinations beginning on August 1 of the same year as the relevant All-Payer QP Performance Period*** (p. 1052)***. CMS finalized that the Submission Deadline for requesting Other Payer Advanced APM determinations (as well as to request QP determinations under the All-Payer Combination Option) is December 1 of the same year as the relevant All-Payer QP Performance Period*** (p. 1052). Medicare Health Plans: ***CMS finalized that APM Entities or eligible clinicians may request Other Payer Advanced APM determinations beginning on August 1 of the same year as the relevant All-Payer QP Performance Period*** (p. 1059)***. CMS finalized that the Submission Deadline for requesting Other Payer Advanced APM determinations (as well as to request QP determinations under the All-Payer Combination Option) is December 1 of the same year as the relevant All-Payer QP Performance Period*** (p. 1059). Remaining Other Payers: ***CMS finalized that APM Entities or eligible clinicians may request Other Payer Advanced APM determinations beginning on August 1 of the same year as the relevant All-Payer QP Performance Period*** (p. 1063)***. CMS proposes that the Submission Deadline for requesting Other Payer Advanced APM determinations (as well as to request QP determinations under the All-Payer Combination Option) is December 1 of the same year as the relevant All-Payer QP Performance Period*** (p. 1063).
CMS Determination	Upon timely receipt of an Eligible Clinician Initiated Submission Form, CMS will use the information submitted to determine whether the other payer arrangement meets the Other Payer Advanced APM criteria. ***CMS finalized that, if it determines that the APM Entity or eligible clinician has submitted incomplete or inadequate information, CMS would inform the APM Entity or eligible clinician and allow the APM Entity or eligible clinician to submit additional information no later than 15 business days from the date informed*** (p. 1034). For each other payer arrangement for which the APM Entity or eligible clinician does not submit sufficient information, CMS would not make a determination in response to that request submitted via the Eligible Clinician Initiated Submission Form. ***These determinations are final and not subject to reconsideration.***
CMS Notification	***CMS finalized that it will notify APM Entities and Eligible Clinicians of determinations for each Other Payer arrangement for which a determination was requested "as soon as practicable" after the Submission Deadline*** (p. 1036).
CMS Posting of Other Payer Advanced APMs	***CMS will post on the CMS Website a list (the "Other Payer Advanced APM List") of all of the other payer arrangements that are determined to be Other Payer Advanced APMs.*** Prior to the start of the relevant All-Payer QP Performance Period, CMS intends to post the Other Payer Advanced APMs that determine through the Payer Initiated Process and Other Payer Advanced APMs under Title XIX that are determined through the Eligible Clinician Initiated Process. After the All-Payer QP Performance Period, CMS would update this list to include Other Payer Advanced APMs that are determine based on other requests through the Eligible Clinician Initiated Process (p. 1036). Medicaid: CMS makes parallel proposals for submissions related to Medicaid APMs and Medicaid Medical Home Models (p. 1036; p. 1046). CMS lists the timeline for Medicaid determinations in Table 38. CMS Multi-Payer Models: CMS makes parallel proposals for CMS Multi-Payer Models and lists the timeline for CMS Multi-Payer Models in Table 39. Medicare Health Plans: CMS makes parallel proposals for Medicare Health Plans and lists the timeline for Medicare Health Plan Models in Table 40. Remaining Other Payers: CMS makes parallel proposals for Remaining Other Payers lists the timeline for Remaining Other Payers in Table 41.

Eligible Clinician Initiated Process	
	CMS finalized its plan to post, on a CMS Web site, only the following information about Other Payer arrangements that are determined to be Other Payer Advanced APMs (p. 1084): • The names of payers with Other Payer Advanced APMs (as specified in the submission form); • The location(s) in which the Other Payer Advanced APMs are available (whether at the nationwide, state, or county level); and • The names of the specific Other Payer Advanced APMs. CMS previously finalized that, to the extent permitted by Federal law, CMS would maintain confidentiality of certain information that APM Entities or eligible clinicians submit for purposes of Other Payer Advanced APM determinations to avoid dissemination of potentially sensitive contractual information or trade secrets. ***CMS also finalized that, with the exception of the specific information proposed for posting above, the information a payer submits through the Payer Initiated Process would be kept confidential to the extent permitted by Federal law, in order to avoid dissemination of potentially sensitive contractual information or trade secrets*** (p. 1084). CMS noted that records that the submitter marks as confidential will be protected from disclosure under FOIA Exemption 4 (p. 1082).
Certification & Program Integrity	CMS previously finalized a requirement that Eligible Clinicians and APM Entities must attest to the accuracy and completeness of data submitted to meet the requirements under the All-Payer Combination Option. CMS believes this requirement would be more appropriately placed in the regulatory provisions that discuss the submission of information related to requests for Other Payer Advanced APM determinations. Accordingly, ***CMS finalized the removal of this requirement as previously finalized and finalized a new requirement in a separate section that an APM Entity or Eligible Clinician that submits information must certify to the best of its knowledge that the information it submitted to us is true, accurate, and complete*** (p. 1079). Under current regulation, APM Entities or eligible clinicians may be subject to audit of the information and supporting documentation provided under the certification. CMS proposed to clarify the nature of the information subject to the record retention requirements***: CMS finalized that an APM Entity or Eligible Clinician must maintain such books, contracts, records, documents, and other evidence as necessary to enable the audit of an Other Payer Advanced APM determination, QP determination, and the accuracy of an APM Incentive Payment for a period of 6 years from the end of the QP Performance Period or from the date of completion of any audit, evaluation, or inspection, whichever is later*** (p. 1078).