

CY 2018 Proposed Updates to the Quality Payment Program (QPP)

A SUMMARY OF THE PROPOSED RULE FOR YEAR 2 OF THE QPP

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On June 20, 2017, the Centers for Medicare and Medicaid Services (CMS) released a rule proposing CY 2018 updates to the Quality Payment Program (QPP). The QPP, established for eligible clinicians under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10, enacted April 16, 2015), includes two tracks for eligible clinicians: Advanced Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS). CMS began implementing the QPP through rulemaking for CY 2017. This proposed rule sets forth policies for the second year of the program.

The following summary provides a high level overview of key sections of the final rule that may be of interest. The rule will be published in the Federal Register on June 30, 2017. Comments are due **August 21, 2017**.

Executive Summary/Background (p. 7)

Overview (p. 7)

CMS continues to review existing policies to identify how to move the program forward and continue to drive improvements in patient outcomes in the least burdensome manner possible. Its goal is to support patients and clinicians in making their own decisions about health care using data driven insights, increasingly aligned and meaningful quality measures, and technology that allows clinicians to focus on providing high quality healthcare for their patients. CMS recognizes the diversity among clinician practices in their experience with quality-based payments and expects the QPP to evolve over multiple years in order to achieve its national goals. This proposed rule is the next part of a staged approach to develop policies that are reflective of system capabilities and grounded in CMS' core strategies to drive progress and reform efforts.

In this proposed rule, CMS addresses elements of MACRA that were not included in the first year of the program, including virtual groups, facility-based measurement, and improvement scoring. It also includes proposals to continue implementing elements of MACRA that do not take effect in the first or second year of the QPP, including policies related to the All-Payer Combination Option for identifying Qualifying Participants (QPs) and assessing eligible clinicians' participation in Other Payer Advanced APMs. In this rule, CMS refers to the second year of the program as "Quality Payment Program Year 2."

QPP Strategic Objectives (p. 11)

CMS outlines its previously developed strategic objectives, along with a new seventh objective:

- 1) To improve beneficiary outcomes and engage patients through patient-centered Advanced APM and MIPS policies;
- 2) To enhance clinician experience through flexible and transparent program design and interactions with easy-to-use program tools;
- 3) To increase the availability and adoption of Advanced APMs;
- 4) To promote program understanding and maximize participation through customized communication, education, outreach and support that meet the needs of the diversity of physician practices and patients, especially the unique needs of small practices;
- 5) To improve data and information sharing to provide accurate, timely, and actionable feedback to clinicians and other stakeholders;
- 6) To promote IT systems capabilities that meet the needs of users and are seamless, efficient and valuable on the front and back-end;
- 7) To ensure operational excellence in program implementation and ongoing development.

One QPP (p. 12)

In this section, CMS reminds readers that:

- Although there are two separate pathways within the QPP, the Advanced APM and MIPS tracks both contribute toward the goal of seamless integration of the QPP into clinical practice workflows.

- Over time, the portfolio of quality measures will grow and develop, driving towards outcomes that are of the greatest importance to patients and clinicians and away from process, or “check the box” type measures.
- The “Pick Your Pace” approach enabled a ramp-up and gradual transition with less financial risk for clinicians in 2017. CMS intends to continue the slow ramp-up of the QPP by establishing special policies in Year 2 aimed at encouraging successful participation in the program while reducing burden, reducing the number of clinicians required to participate, and preparing clinicians for the CY 2019 performance period.

Summary of the Major Provisions ([p. 14](#))

QPP Year 2 ([p. 14](#))

CMS continues to believe that a second transition period is necessary to build upon the iterative learning and development period as it builds towards a steady state.

Small Practices ([p. 14](#))

The support of small, independent practices remains an important thematic objective for the QPP and is expected to be carried throughout future rulemaking. In response to feedback from small practices that challenges still exist, CMS proposes additional flexibilities including:

- **Implementing the virtual groups provisions;**
- **Increasing the low-volume threshold to less than or equal to \$90,000 in Medicare Part B allowed charges or less than or equal to 200 Medicare Part B patients;**
- **Adding a significant hardship exception from the advancing care information (ACI) performance category for MIPS eligible clinicians in small practices; and**
- **Providing bonus points that are added to the final scores of MIPS eligible clinicians who are in small practices.**

Under MACRA, during a period of 5 years, \$100 million in funding was provided for technical assistance to be available to provide guidance and assistance to MIPS eligible clinicians in small practices through contracts with regional health collaboratives, and others. Guidance and assistance on the MIPS performance categories or the transition to APM participation will be available to MIPS eligible clinicians in practices of 15 or fewer clinicians with priority given to practices located in rural areas or medically underserved areas (MUAs), and practices with low MIPS final scores. More information on the technical assistance support available to small practices can be found [here](#).

CMS estimates that at least 80% of clinicians in small practices with 1-15 clinicians will receive a positive or neutral MIPS payment adjustment.

Summary of Major Provisions for Advanced APMs ([p. 15](#))

Approximately 180,000 to 245,000 eligible clinicians may become QPs for payment year 2020 based on Advanced APM participation in performance year 2018. In the 2017 QPP final rule, CMS estimated that 70,000 to 120,000 eligible clinicians would be QPs for payment year 2019 based on Advanced APM participation in performance year 2017. However, with new Advanced APMs expected to be available for participation in 2018, including the Medicare ACO Track 1 Plus (1+) Model, and the reopening of the application process to new participants for some current Advanced APMs, such as the Next Generation ACO Model and Comprehensive Primary Care Plus Model, CMS anticipates higher numbers of QPs in 2018.

Other proposals related to Advanced APMs include:

- In regards to the requirements that Advanced APMs require participating entities to bear more than nominal risk for monetary losses, **CMS proposes to maintain the generally applicable revenue-based nominal amount standard at 8% of the estimated average total Parts A and B revenue of eligible clinicians in participating APM Entities for QP Performance Periods 2019 and 2020.**

- **CMS proposes to make qualifying participant (QP) determinations using payment or patient data only for the dates that APM Entities were able to participate in the Advanced APM per the terms of the Advanced APM, not for the full Medicare QP Performance Period.**
- **In regards to the the All-Payer Combination Option, which uses a calculation based on both the Medicare Option and participation in Other Payer Advanced APMs to conduct QP determinations and is applicable beginning in performance year 2019, CMS proposes to:**
 - **Add a revenue-based nominal amount standard in addition to the benchmark-based nominal amount standard that would be applicable only to payment arrangements in which risk is expressly defined in terms of revenue;**
 - **Conduct all QP determinations under the All-Payer Combination Option at the individual eligible clinician level;**
 - **Establish an All-Payer QP Performance Period to assess participation in Other Payer Advanced APMs; and**
 - **Establish a Payer Initiated Other Payer Advanced APM Determination Process, which would allow certain other payers to request that CMS determine whether their payer arrangements are Other Payer Advanced APMs starting prior to the 2019 All-Payer QP Performance Period and each year thereafter.**

In regards to the Physician-Focused Payment Model Technical Advisory Committee (PTAC), the federal advisory committee that serves as an important avenue for the creation of innovative payment models, **CMS seeks comments on broadening the definition of Physician-Focused Payment Models (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.**

Summary of Major Provisions for MIPS (p. 20)

CMS proposes the following policies related to MIPS for QPP Year 2, which encompasses the 2018 performance periods and 2020 payment year:

Quality

- **Quality would continue to comprise 60% of the total MIPS composite score** despite a previously finalize policy of 50% for the 2020 payment year;
- **CMS would maintain the 50% data completeness threshold for QCDRs, qualified registries, EHRs and claims-based data submissions,** despite a previously finalized policy of 60% for the 2018 performance period. **However, CMS proposes to raise it to 60% in 2019 and anticipates it will increase over time.**

Improvement Activities (IA)

- **The IA category would continue to comprise 15% of the total MIPS composite score for the 2020 payment year;**
- **No changes in IA scoring;**
- **Newly proposed IAs (Table F) and changes to existing IAs (Table G)**
- **CMS would expand its definition for recognizing an individual MIPS eligible clinician or group as being a certified patient-centered medical home or comparable specialty practice (and thus being eligible to receive full credit in this category) to include practices that have been randomized to the control group in the CPC+ model.**
- **CMS would require that at least 50% of practice sites within a TIN must be recognized as a certified or recognized patient-centered medical home or comparable specialty practice to receive full credit in this category.**

Cost

- **Cost would continue to comprise 0% of the total MIPS composite score;**
- **CMS would continue to provide confidential feedback on the Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Costs for All Attributed Beneficiaries measures, but not the 10 episodes**

previously finalized in 2017.

- *CMS intends to provide confidential feedback on new episode-based cost measures currently under development in the fall of this year and feedback on another set of newly developed episode-based cost measures in 2018.*

Advancing Care Information (ACI)

- *ACI would continue to comprise 25% of the total MIPS composite score. However, if a MIPS eligible clinician is participating in a MIPS APM, the ACI category may comprise 30% or 75% of the final score depending on the availability of APM quality data for reporting;*
- *Eligible clinicians could continue to use 2014 Edition CEHRT in 2018;*
- *Minor changes to measures, adding an exclusion to e-Prescribing and Health Information Exchange Objectives, and modifying the scoring policy for the Public Health and Clinical Data Registry Reporting Objectives and Measures for the performance score and bonus score;*
- *Implements several provisions of the 21st Century Cures Act (Pub. L. 114-255) pertaining to hospital-based MIPS eligible clinicians, ambulatory surgical center (ASC)-based MIPS eligible clinicians, MIPS eligible clinicians using decertified EHR technology, and significant hardship exceptions under the MIPS, including the addition of a significant hardship exception for MIPS eligible clinicians in small practices.*

Submission Mechanisms

- *Individuals and groups would be able to submit measures and activities via as many data submission mechanisms as necessary.*

Virtual Groups

- *Establishes requirements for MIPS participation at the virtual group level, defined as a combination of two or more TINs composed of a solo practitioner or a group with 10 or fewer eligible clinicians under a 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.*
- *CMS intends to make technical assistance available to support clinicians who choose this option for 2018 and 2019.*

MIPS APMs and APM Scoring Standard

- *Proposes modifications to the quality performance category reporting requirements and scoring for MIPS eligible clinicians in most MIPS APMs, including the adoption of 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;*
- *Adds a fourth snapshot date that would be used only to identify APM Entity groups participating in those MIPS APMs that require full TIN participation.*

Facility-based Measurement

- *For clinicians whose primary professional responsibilities are in a healthcare facility, CMS presents policies to assess clinician performance in the quality and cost performance categories of MIPS based on the performance of that facility in another value-based purchasing program;*
- *Although CMS proposes to limit this policy to clinicians who practice primarily in the hospital, it seeks to expand the program to other value-based payment programs as appropriate in the future.*

Scoring

- *Proposes to build on the unified scoring methodology used in 2017, focusing on encouraging MIPS eligible clinicians to meet data completeness requirements;*
- *In regards to quality, CMS proposes to:*
 - *Maintain the 3 point floor for measures that can be reliably scored against a benchmark;*

- *Maintain the policy to assign 3 points to measures that are submitted, but do not have a benchmark or do not meet the case minimum;*
- *Lower the number of points available for measures that do not meet the data completeness criteria, except for a measure submitted by a small practice, which would continue to receive 3 points if the measure does not meet data completeness;*
- *Proposes to add performance standards for scoring improvement for the quality and cost performance categories.*
- *Proposes a systematic approach to address topped out quality measures.*
- *Proposes to add final score bonuses for small practices and for MIPS eligible clinicians that care for complex patients.*
- *Final scores would be compared against a MIPS performance threshold of 15 points, rather than 3 points, which can be achieved via multiple pathways and continues the gradual transition into MIPS.*

Performance Feedback

- *CMS intends to provide performance feedback on an annual basis; in future years aims to provide feedback on a more frequent basis.*

Third Party Intermediaries

- *Eliminates the self-nomination submission method of email and require that QCDRs and qualified registries submit applications via a web-based tool;*
- *Beginning with the 2019 performance period, proposes a simplified process in which existing QCDRs or qualified registries in good standing may continue their participation in MIPS by attesting that their approved data validation plan, cost, approved QCDR measures, MIPS quality measures, activities, services, and performance categories offered in the previous year's performance period of MIPS have no changes.*
 - *QCDRs and qualified registries in good standing, may also make substantive or minimal changes to their approved self-nomination application from the previous year of MIPS that would be submitted during the self-nomination period for CMS review and approval.*

Public Reporting

- *Proposes the public reporting of certain eligible clinician and group QPP information, including MIPS and APM data in an easily understandable format as required under the MACRA.*

Eligibility and Exclusion Provisions of the MIPS Program

- *Proposes to specify that groups considered to be non-patient facing (more than 75% of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician) during the determination period would automatically have their ACI performance category reweighted to zero;*
- *Proposes to modify the definition of a non-patient facing MIPS eligible clinician to apply to virtual groups;*
- *Proposes to increase the low-volume threshold policy established previously to less than or equal to \$90,000 in Medicare Part B charges or 200 or fewer Part-B enrolled Medicare beneficiaries.*

Payment Adjustments ([p. 30](#))

For the 2020 payment year, CMS estimates that about 180,000 to 245,000 clinicians will become QPs, and therefore be exempt from MIPS and qualify for lump sum incentive payments based on 5% of their Part B allowable charges for covered professional services, estimated to be between approximately \$590 and \$800 million for the 2020 QPP payment year.

CMS estimates that approximately 572,000 eligible clinicians would be required to participate in MIPS in the 2018 MIPS performance period, although this number may vary depending on the number of eligible clinicians excluded from MIPS based on their status as QPs or Partial QPs. The proposed increase in the low-volume

threshold is expected to exclude 585,560 clinicians.

Assuming that 90% of eligible clinicians of all practice sizes participate in MIPS, CMS estimates that MIPS payment adjustments will be approximately equally distributed between negative MIPS payment adjustments (\$173 million) and positive MIPS payment adjustments (\$173 million) to MIPS eligible clinicians, as required by the statute to ensure budget neutrality. Positive MIPS payment adjustments will also include up to an additional \$500 million for exceptional performance to MIPS eligible clinicians whose final score meets or exceeds the additional performance threshold of 70 points. CMS believes that starting with these modest initial MIPS payment adjustments is in the long-term best interest of maximizing participation and starting the QPP off on the right foot, even if it limits the magnitude of MIPS positive adjustments during the 2018 MIPS performance period.

Benefits and Costs of Proposed Rule (p. 32)

CMS estimates that this proposed rule will result in approximately \$857 million in collection of information-related burden, compared to the estimated burden of continuing the policies in the CY 2017 QPP final rule, which is \$869 million. CMS also estimates regulatory review costs of \$4.8 million for this proposed rule, comparable to the regulatory review costs of the CY 2017 QPP proposed rule.

Provisions of the Proposed Regulations (p. 34)

Definitions (p. 34)

At §414.1305, subpart O, CMS proposes to define numerous terms discussed throughout this rule. A list of these definitions can be found [here](#).

MIPS Program Details (p. 36)

MIPS Eligible Clinicians (p. 36)

Definition of a MIPS Eligible Clinician (p. 36)

CMS reiterates its previously established definition of a MIPS eligible clinician here.

It also provides clarification 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. CMS notes that when Part B items or services are rendered 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. CMS highlights the following circumstances:

- If a MIPS eligible clinician 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 durable medical equipment 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 allowable 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.
- For Part B items and services furnished by a MIPS eligible clinician such as purchasing and administering Part B drugs that are billed by the MIPS eligible clinician, such items and services may be subject to MIPS adjustment based on the MIPS eligible clinician's performance during the applicable performance period or included for eligibility determinations.
- For those billed Medicare Part B allowable charges relating to the purchasing and administration of Part B drugs that CMS is able to associate with a MIPS eligible clinician at an NPI level, such items and services furnished by the MIPS eligible clinician would be included for purposes of applying the MIPS payment adjustment or making eligibility determinations.

Group Practice (p. 37)

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.

CMS reiterates that an APM Entity group is defined as a group of eligible clinicians participating in an APM Entity, as identified by a combination of the APM identifier, APM Entity identifier, TIN, and NPI for each participating eligible clinician.

Small Practices (p. 38)

In the 2017 QPP final rule, CMS defined small practices as those consisting of 15 or fewer clinicians and solo practitioners. CMS also finalized that it would not make eligibility determinations regarding the size of small practices, but that small practices are expected to attest to the size of their group practice. However, given policy changes in this rule intended to assist small practices, CMS now has operational reasons to account for small practice size in advance of a performance period, such as assessing and scoring IA performance, determining hardship exceptions for small practices, calculating the small practice bonus for the final score, and identifying small practices eligible for technical assistance.

Thus, for eligibility determinations regarding the size of small practices for performance periods occurring in 2018 and future years, CMS proposes to determine the size of small practices. As previously finalized, the size of a group (including a small practice) would be determined before exclusions are applied. In other words, group size determinations are based on the number of NPIs associated with a TIN, which would include NPIs who may be excluded from MIPS participation and do not meet the definition of a MIPS eligible clinician.

For performance periods occurring in 2018 and future years, CMS proposes to determine the size of small practices by utilizing claims data. The “small practice size determination period” would span a 12-month period, which would consist 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. Thus, for purposes of the 2018 performance period, CMS would identify small practices based on 12 months of data starting from September 1, 2016 to August 31, 2017. This would allow CMS to inform small practices of their status near the beginning of the performance period. CMS would not change an eligibility determination regarding the size of a small practice once the determination is made for a given performance period.

CMS recognizes that there may be circumstances in which the small practice size determinations made by CMS do not reflect the real-time size of such practices. ***It considered two options related to determining small practice size, which it seeks comments on:***

- 1) ***Expand the proposed small practice size determination period to 24 months with two 12-month segments of data analysis (before and during the performance period), in which CMS would conduct a second analysis of claims data during the performance period.*** While this might be more accurate, determinations made during the performance period would prevent CMS from being able to account for the assessment and scoring of the IA performance category and identification of small practices eligible for technical assistance *prior* to 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.*** This would require CMS to develop a manual attestation mechanism and a verification process to ensure that only small practices are identified as eligible for technical assistance. Since individual MIPS eligible clinicians and groups are not required to register to participate in MIPS (except for groups utilizing the CMS Web Interface or

administering the CAHPS for MIPS survey), requiring small practices to attest to the size of their group practice prior to the performance period could increase burden on those clinicians.

Rural Area and Health Professional Shortage Area Practices (p. 41)

Recognizing that individual MIPS clinicians or groups may have multiple practice sites associated with its TIN, CMS clarifies that for 2017, it considers an individual MIPS eligible clinician or a group with at least one practice site under its TIN in a ZIP code designated as a rural area or HPSA to be a rural area or HPSA practice.

For 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 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. CMS believes this policy will add consistency for such practices across MIPS as it pertains to groups and virtual groups obtaining such statuses and that this threshold renders an adequate representation of a group or virtual group where a significant portion of a group or a virtual group is identified as having such status.

Non-Patient Facing MIPS Eligible Clinicians (p. 42)

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.

CMS intends to again publish a list of *patient-facing* encounter codes that it will use to determine the *non-patient facing status* of MIPS clinicians in 2018 at <https://qpp.cms.gov/> by the end of 2017. The list of patient-facing encounter codes will again include two general categories of codes: Evaluation and Management (E&M) codes; and Surgical and Procedural codes.

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. This means that CMS would initially identify individual MIPS eligible clinicians and groups who are considered non-patient facing MIPS eligible clinicians based on 12 months of data starting from September 1, 2016, to August 31, 2017. To account for the identification of additional individual MIPS eligible clinicians and groups, it would conduct another eligibility determination analysis based on 12 months of data starting from September 1, 2017, to August 31, 2018. This decision was based on an analysis of data, where CMS found that it could achieve a similar outcome for such eligibility determinations by utilizing a 30-day claims run out rather than a 60-day claims run out (see [Table 1](#) for data completeness regarding comparative analysis of a 60-day and 30-day claims run out).

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 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) (p. 48)

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.

MIPS Eligible Clinicians Who Practice in Rural Health Clinics (RHCs) or Federally Qualified Health Centers (FQHCs) (p. 49)

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. However, these eligible clinicians have the option to voluntarily report on applicable measures and activities for MIPS, in which the data received will not be used to assess their performance for the purpose of the MIPS payment adjustment.

MIPS Eligible Clinicians Who Practice in Ambulatory Surgical Centers (ASCs), Home Health Agencies (HHAs), Hospice, and Hospital Outpatient Departments (HOPDs) (p. 49)

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 clarifies that these eligible clinicians have the option to voluntarily report on applicable measures and activities for MIPS, in which the data received would not be used to assess their performance for the purpose of the MIPS payment adjustment. CMS clarifies that eligible clinicians who bill under both the PFS and one of these other billing methodologies (ASC, HHA, Hospice, and/or HOPD) may be required to participate in MIPS if they exceed the low-volume threshold and are otherwise eligible clinicians; in such case, data reported would be used to determine their MIPS payment adjustment.

MIPS Eligible Clinician Identifier (p. 50)

CMS simply 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. As previously established, each unique TIN/NPI combination is considered a different MIPS eligible clinician, and MIPS performance is assessed separately for each TIN under which an individual bills.

Exclusions (p. 51)

CMS sets forth the following exclusion policies related to the 2018 MIPS performance period:

New Medicare-Enrolled Eligible Clinician (p. 51)

CMS proposes no changes to this definition or the status of this current exclusion.

Qualifying APM Participant (QP) and Partial Qualifying APM Participant (Partial QP) (p. 52)

CMS proposes no changes to this definition or the status of this current exclusion.

Low-Volume Threshold (p. 52)

CMS proposes to modify this threshold 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 (versus the 2017 policy of less than or equal to \$30,000 OR providing care for 100 or

fewer Part B Medicare beneficiaries). This adjustment is intended to further reduce the number of clinicians that are required to participate in MIPS, which would reduce the burden on clinicians practicing in small practices and designated rural areas. This would exclude approximately 134,000 additional clinicians from MIPS in 2018, from the approximately 700,000 clinicians that would have been eligible based on the low-volume threshold that was finalized in 2017. Almost half of the additionally excluded clinicians are in small practices and approximately 17% are clinicians from practices in designated rural areas. If this policy were adopted, it would mean that 37% of individual MIPS eligible clinicians and groups would be in MIPS based on the low-volume threshold exclusion (and the other exclusions). However, 65% of Medicare payments would still be captured under MIPS, compared to 72.2% of Medicare payments in 2017.

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 MIPS eligible clinicians participating in the MIPS APM Entity would be excluded from 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.

For 2018 and future years, ***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.*** Thus, for 2018, CMS would initially identify individual eligible clinicians and groups that do not exceed the low-volume threshold based on 12 months of data starting from September 1, 2016 to August 31, 2017, and conduct another eligibility determination analysis based on 12 months of data starting from September 1, 2017 to August 31, 2018. CMS would not change the low-volume status of any individual eligible clinician or group identified as not exceeding the low-volume threshold during the first eligibility determination analysis based on the second eligibility determination analysis.

Also, low-volume threshold determinations would be made at the individual and group level, and not at the virtual group level.

CMS notes that under section 1848(q)(1)(C)(iv) of the Act, it has the authority to select a low-volume threshold based on one or more of the following:

- The minimum number, as determined by the Secretary, of Part B-enrolled individuals who are treated by the MIPS eligible clinician for a particular performance period;
- The minimum number, as determined by the Secretary, of items and services furnished to Part B-enrolled individuals by the MIPS eligible clinician for a particular performance period; and
- The minimum amount, as determined by the Secretary, of allowed charges billed by the MIPS eligible clinician for a particular performance period.

Although CMS has not yet made proposals specific to a minimum number of items and service furnished to Part-B enrolled individuals by a MIPS eligible clinician, it has assessed this option in order to expand the ways in which claims data could be analyzed for purposes of determining a more comprehensive assessment of the low-volume threshold. CMS has considered defining items and services by using the number of patient encounters or procedures associated with a clinician. Defining items and services by patient encounters would assess each patient per visit or encounter with the MIPS eligible clinician, which is a simple and straightforward approach, but it could also incentivize clinicians to focus on volume of services rather than the value of services provided to patients. Alternatively, defining items and services by procedure would tie a specific clinical procedure rendered to a patient to a clinician. ***CMS solicits comment on these and other methods of defining items and services furnished by clinician for purpose of the low-volume threshold.***

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. For example, if a clinician meets the low-volume threshold of \$90,000 in allowed charges, but does not meet the threshold of 200 patients, the clinician should have the opportunity to choose whether or not to participate in MIPS and be subject to payment adjustments. The intent here is to expand options for clinicians by offering them the ability to participate in MIPS if they otherwise would not be included. CMS recognizes that this choice would present additional complexity to clinicians in understanding all of their available options and may impose additional burden on clinicians by requiring them to notify CMS of their decision, which is why CMS does not propose to offer this additional flexibility until 2019. **CMS also seeks comment on any additional considerations/scenarios it should address when establishing this opt-in policy.** For example, should CMS establish parameters for individual clinicians or groups who elect to opt-in to participate in MIPS, such as required length of participation? Additionally, this opt-in policy could impact CMS' ability to create quality benchmarks that meet its sample size requirements. For example, if particularly small practices or solo practitioners with low Part B beneficiary volumes opt-in, such clinician's may lack sufficient sample size to be scored on many quality measures, especially measures that do not apply to all of a MIPS eligible clinician's patients.

Group Reporting (p. 62)

In the 2017 final rule, CMS adopted a policy of not making an eligibility determination regarding group size, but indicated that groups would attest to their group size for purpose of using the CMS Web Interface or a group identifying as a small practice. **As discussed [here](#), CMS proposes to modify this policy by using claims data to make small practice size determinations. As discussed in this [section](#), CMS also would adopt this policy for clinicians seeking to form or join a virtual group.**

Group size determinations are based on the number of NPIs associated with a TIN, which would include clinicians who may be excluded from MIPS participation and do not meet the definition of a MIPS eligible clinician.

CMS does not propose any changes to its group practice registration policies from 2017.

In response to public feedback and to foster more effective measurement, CMS seeks comments to inform future rulemaking on ways to establish group-related policies that would permit a portion of a group to participate in MIPS outside the group by reporting as a separate subgroup. CMS would create such functionality through a new identifier.

Virtual Groups (p. 65)

Section 1848(q)(5)(I)(i) of the Act provides that MIPS eligible clinicians electing to be a virtual group must:

- 1) Have their performance assessed for the quality and cost performance categories in a manner that applies the combined performance of all the MIPS eligible clinicians in the virtual group to each MIPS eligible clinician in the virtual group for the applicable performance period; and
- 2) Be scored for the quality and cost performance categories based on such assessment

For 2018, CMS proposes 3 ways to participate in MIPS:

- (1) Individual-level reporting;**
- (2) Group-level reporting; and**
- (3) Virtual group-level reporting**

In order to provide support and reduce burden, CMS intends to make technical assistance available, to the extent feasible and appropriate, to support clinicians who choose to come together as a virtual group.

Definition of a Virtual Group (p. 66)

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 would need to include at least one MIPS eligible clinician in order to be eligible to join or form a virtual group.

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

CMS also clarifies that while entire TINs participate in a virtual group, including each NPI under a TIN, and are assessed and scored collectively as a virtual group, only NPIs that meet the definition of a MIPS eligible clinician would be subject to a MIPS payment adjustment. The MIPS adjustment would not apply to NPIs who are excluded from MIPS (e.g., new to Medicare; QP; Partial QP who chooses not to participate in MIPS; and those who do not exceed the low-volume threshold). **Also, any MIPS eligible clinician who is part of a TIN participating in a virtual group and participating in a MIPS APM or Advanced APM under the MIPS APM scoring standard would not receive a MIPS payment adjustment based on the virtual group's final score, but would receive a payment adjustment based on the MIPS APM scoring standard.** Similar to policies established for groups in 2017, for groups other than groups containing participants in a MIPS APM or an Advanced APM, each MIPS eligible clinician (TIN/NPI) would receive a MIPS adjustment based on the virtual group's combined performance assessment (combination of TINs). For groups containing 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 (TIN/NPI) would receive a 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 (TIN/NPI) receives a MIPS adjustment based on that standard, or may be exempt from MIPS if they achieve QP or Partial QP status.

CMS does not propose to establish any required classifications regarding virtual group composition. Although the statute gives CMS the flexibility to base the virtual group on classifications of providers, such as by geographic areas or by provider specialties, CMS believes it is important for virtual groups to have the flexibility to determine their own composition at this time.

To maintain flexibility, CMS also does not propose at this time to establish a limit on the number of TINs that may form a virtual group limit at this time. However, it will monitor ways in which clinicians form virtual groups and may propose to establish appropriate classifications regarding virtual group composition or a limit on the number of TINs that may form a virtual group in future rulemaking. CMS did consider a limit, such as 50 or 100 participants, to ensure virtual groups are not too substantial in size (e.g. 10% of all MIPS eligible clinicians in a given specialty or sub-specialty), which may make it difficult to compare performance between and among clinicians, but opted to instead leave that decision up to the virtual group.

As noted [earlier](#), 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 separately or forming a virtual group. CMS solicits public comment on this potential strategy.

[MIPS Virtual Group Identifier for Performance \(p. 71\)](#)

To ensure it has accurately captured all of the MIPS eligible clinicians participating in a virtual group, **CMS proposes that each MIPS eligible clinician who is part of a virtual group would be identified by a unique virtual group participant identifier**, which would be a combination of three identifiers: (1) virtual group identifier (established by CMS; for example, XXXXXX); (2) TIN (9 numeric characters; for example, XXXXXXXXX); and (3) NPI (10 numeric characters; for example, 1111111111). For example, a virtual participant identifier could be VG-XXXXXX, TIN- XXXXXXXXX, NPI-1111111111.

[Application of MIPS Group Policies to Virtual Groups \(p. 71\)](#)

CMS proposes to apply its previously finalized and newly proposed group policies to virtual groups:

- **Applicability of the 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 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).

CMS seeks comments on these policies; particularly, whether group-related policies previously established and proposed in this rule should or should not apply to virtual groups. CMS also requests comment on any other policies that may need to be clarified or modified with respect to virtual groups.

[Virtual Group Election Process \(p. 73\)](#)

A 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 performance year and future years, CMS proposes that those electing to be in a virtual group must do so by December 1 of the calendar year preceding the applicable performance period. As noted below, groups would be able to inquire about virtual group participation eligibility as early as September of each year prior to the applicable performance period. Prior to the election deadline, a virtual group representative would have the opportunity to make an election, on behalf of the members of a virtual group. CMS intends to publish the beginning date of the virtual group election period applicable to the 2018 performance period in sub-regulatory guidance.

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 proposes a two-stage virtual group election process:

- **Stage 1:** Pertains to virtual group eligibility determinations and would be optional for the applicable 2018 and 2019 performance periods. In stage 1, those interested in forming or joining a virtual group would have the option to contact their designated technical assistance (TA) representative or the QPP Service Center in order to obtain information pertaining to virtual groups and/or determine whether or not they are eligible. Stage 1 would not be required, but simply a resource. For solo practitioners and groups who engage in stage 1 and were determined eligible for virtual group participation, they would proceed to stage 2. Engaging in stage 1 would allow clinicians to confirm whether or not they are eligible to join or form a virtual group before going to the lengths of executing formal written agreements, submitting a formal election registration, allocating resources for virtual group implementation, and other related activities; whereas, engaging directly in stage 2 as an initial step, clinicians could be rejected with no recourse or remaining time to amend and resubmit.
- **Stage 2:** For groups that do not choose to participate in stage 1 of the election process, CMS will make an eligibility determination during stage 2 of the election process. Stage 2 would require:
 - TINs comprising a virtual group must establish a written formal agreement between each member of a virtual group prior to an election;

- On behalf of a virtual group, the official designated virtual group representative must submit an election by December 1 of the calendar year prior to the start of the applicable performance period.
- The election must include, at a minimum, information pertaining to each TIN and NPI associated with the virtual group and contact information for the virtual group representative. The election must also confirm through acknowledgment that a written formal agreement has been established between each member of the virtual group prior to election and each member of the virtual group is aware of participating in MIPS as a virtual group for an applicable performance period. Note that the virtual group agreement would be subject to the MIPS data validation and auditing requirements described elsewhere in this rule.

CMS anticipates this election will occur via e-mail to the QPP Service Center using the following email address: MIPS_VirtualGroups@cms.hhs.gov. For Program Year 3, CMS intends to provide an electronic election process if technically feasible.

Virtual Group Eligibility Determinations (p. 76)

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. As noted earlier, TIN size determinations are based on the number of NPIs associated with a TIN, which would include clinicians (NPIs) excluded from MIPS participation and who do not meet the definition of a MIPS eligible clinician.

During stage 2 of the election process, CMS will consider the following:

- Confirm whether or not each TIN within a virtual group is eligible to participate in MIPS as part of a virtual group;
- Identify the NPIs within each TIN participating in a virtual group that are excluded from MIPS in order to ensure that such NPIs would not receive a MIPS payment adjustment or, when applicable, would receive a payment adjustment based on a MIPS APM scoring standard;
- Calculate the low-volume threshold at the individual and group levels in order to determine whether or not a solo practitioner or group is eligible to participate in MIPS as part of a virtual group. ***Note that solo practitioners or groups with 10 or fewer eligible clinicians that are determined not to exceed the low-volume threshold at the individual or group level, respectively, would not be eligible to participate in MIPS as an individual, group, or virtual group.***

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 a calendar year prior to the performance year and include a 30-day claims run out. To capture a real-time representation of TIN size, CMS proposes to analyze up to five months of claims data on a rolling basis, in which virtual group eligibility determinations for each TIN would be updated and made available monthly. TINs could determine their status by contacting their designated TA representative or the QPP Service Center; otherwise, the TIN’s status would be determined at the time that the TIN’s virtual group election is submitted. For example, if a group contacted their designated TA representative or QPP Service Center on October 20, 2017, the claims data analysis would include the months of July through September of 2017. If another group reached out on November 20, 2017, the claims data analysis would include the months of July through October of 2017. ***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.***

It is anticipated that starting in September of each calendar year prior to the applicable performance year beginning in 2018, groups would be able to contact their designated TA representative or the QPP Service Center and inquire about virtual group participation eligibility. CMS recognizes that for the first year of virtual group formation prior to the start of the 2018 performance period, the timeframe for virtual groups to make an election would be relatively short since the final rule will not be issued until toward the end of 2017. ***To provide clinicians with additional time to assemble and coordinate resources, and form a virtual group prior to the start of the 2018 performance period, CMS is providing virtual groups with an opportunity to make an election prior to the publication of our final rule. It intends for this election process to be available as early as mid-September of 2017, and will publicize the specific opening date via sub-regulatory guidance. Thus, virtual groups would have from mid-September to December 1, 2017 to make an election for the 2018 performance year.*** Although CMS will conduct this early process in alignment with its proposed policies, MIPS eligible clinicians applying to be a virtual group must ultimately satisfy all *finalized* virtual group requirements.

Once a determination is made, CMS will then notify virtual groups as to whether or not they are considered official virtual groups for the applicable performance period. For virtual groups that are determined to have met the criteria, CMS would contact the official designated virtual group representative via e-mail and issue it a virtual group identifier for performance that would accompany the virtual group's submission of performance data during the submission period.

Although the virtual group size would be determined one time for each performance period, CMS recognizes that the size of a group may fluctuate during a performance period with 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.*** The virtual group representative is expected to relay this information, and any other changes to the group through the performance period, to CMS. Virtual groups also must re-register before each performance period. ***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.***

Given that a virtual group must be a combination of TINs, CMS recognizes that the composition of a virtual group could include, for example, one solo practitioner (NPI) who is practicing under multiple TINs, in which the solo practitioner would be able to form a virtual group with his or her own self based on each TIN assigned to the solo practitioner. ***CMS notes here that there is not a limit to the number of TINs able to comprise a virtual group.***

Virtual Group Agreements (p. 82)

As required by statute, ***CMS proposes that each virtual group member would be required to 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.*** A virtual group may not include a solo practitioner or group as part of the virtual group unless an authorized person of the TIN has executed a formal written agreement.

CMS seeks comments on whether the following written agreement requirements balance the need to ensure all members of a virtual group are aware of their participation in a virtual group and the minimization of administration burden:

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

- Be executed on behalf of the TINs and the NPIs by individuals who are authorized to bind the TINs and the NPIs.
- Expressly require each member of the virtual group (including each NPI under each TIN) to agree 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, Health Insurance Portability and Accountability Act, and physician self-referral law).
- Require each TIN within a virtual group to notify all NPIs associated with the TIN of their participation in the MIPS as a virtual group.
- Set forth the NPI's rights and obligations in, and representation by, the virtual group, including without limitation, the reporting requirements and how participation in MIPS as a virtual group affects the ability of the NPI to participate in the MIPS outside of the virtual group.
- Describe how the opportunity to receive payment adjustments will encourage each member of the virtual group (including each NPI under each TIN) to adhere to quality assurance and improvement.
- Require each member of the virtual group to update its Medicare enrollment information, including the addition and deletion of NPIs billing through a TIN that is part of a virtual group, on a timely basis in accordance with Medicare program requirements and to notify the virtual group of any such changes within 30 days after the change.
- Be for a term of at least one performance period as specified in the formal written agreement.
- Require completion of a close-out process upon termination or expiration of the agreement that requires the TIN (group part of the virtual group) or NPI (solo practitioner part of the virtual group) to furnish all data necessary in order for the virtual group to aggregate its data across the virtual group.

On June 14, 2017, CMS released an [Information Collection Request](#) that includes an agreement template that could be used by virtual groups. The agreement template is not required, but serves as a model agreement that includes all necessary elements required for such an agreement.

Virtual Group Reporting Requirements (p. 85)

CMS believes virtual groups should generally be treated under the MIPS as groups. Thus, for MIPS eligible clinicians participating at the virtual group level, it proposes 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.***
- ***Individual 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 the election process established and required by CMS.***

Assessment and Scoring of Virtual Groups for the MIPS Performance Categories (p. 86)

Although Section 1848(q)(5)(I)(i) of the Act provides that eligible clinicians electing to be a virtual group will “have their performance assessed for the quality and cost performance categories” and be scored based on the combined performance “regarding the quality and cost performance categories for a performance period,” ***CMS clarifies here its proposal that virtual groups would be assessed and scored across all four MIPS performance categories at the virtual group level for a performance period of a year.*** CMS believes it is critical for virtual groups to be assessed and scored at the virtual group level for all performance categories since this eliminates the burden of virtual group members having to report as a virtual group and separately outside of a virtual group. It also provides for a comprehensive measurement of performance, shared responsibility, and an

opportunity to effectively and efficiently coordinate resources to also achieve performance under the improvement activities and the advancing care information performance categories.

CMS reiterates here that it 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 has 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.

MIPS Performance Period ([p. 90](#))

2020 MIPS payment year.

- For the quality and cost categories, the performance period would be 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 year and future years

- For the quality and cost performance categories, the performance period under MIPS would be the full calendar year that occurs two years prior to the applicable payment year (e.g. 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.

MIPS Performance Category Measures and Activities ([p. 92](#))

Submission Mechanisms ([p. 92](#))

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 to receive the maximum number of points under a performance category. For example, an individual MIPS eligible clinician or group submitting data on four applicable and available quality measures via EHR may not be able to receive the maximum number of points available under the quality performance category. However, with this proposed modification, the MIPS eligible clinician could meet the requirement to report six quality measures by submitting data on two additional quality measure via another submission mechanism, such as claims or qualified registry. CMS recognizes that this proposal for increased flexibility in data submission mechanisms may increase complexity and in some instances additional costs for clinicians, as they may need to establish relationships with additional data submission mechanism vendors in order to report additional measures and/or activities for any given performance category. The use of multiple data submission mechanisms also might limit CMS' ability to

provide real-time feedback. CMS also considered an approach that would require MIPS eligible clinicians to first submit data on as many required measures and activities as possible via one submission mechanism before submitting data via an additional submission mechanism, but believes that such an approach would limit flexibility. ***CMS strives to minimize complexity and administrative burden on clinicians and thus, seeks comments on its proposal.***

CMS clarifies that if an individual MIPS eligible clinician or group submits the same measure through two different mechanisms, each submission would be calculated and scored separately since CMS does not have the ability to aggregate data on the same measure across submission mechanisms. CMS would only count the submission that gives the clinician the higher score, thereby avoiding the double count.

For virtual groups, CMS proposes they, too, 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.

Submission Deadlines (p. 97)

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).*** The submission period will begin prior to January 2 following the close of the performance period, if technically feasible.
- ***Data must be submitted on claims with dates of service during the performance period that must be processed no later than 60 days following the close of the performance period.***
- ***For 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.*** The specific deadline during this timeframe will be published on the CMS website.

Quality Performance Criteria (p. 98)

CMS clarifies here that the statute does not specify the number of quality measures on which a MIPS eligible clinician must report, nor does it specify the amount or type of information that a MIPS eligible clinician must report on each quality measure. However, section 1848(q)(2)(C)(i) of the Act requires the Secretary, as feasible, to emphasize the application of outcomes-based measures.

Contribution to Final Score (p. 100)

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%. This is a modification from CMS' previously finalized decision to apply a 50% weight to the quality category for the 2020 payment year.

A 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.

Quality Data Submission Criteria (p. 103)

Except with regard to the CAHPS for MIPS survey, discussed below, CMS does not propose any changes to the submission criteria or definitions established for measures in the 2017 final rule.

- **Web Interface (p. 107).** ***CMS does not propose any changes to the submission criteria for quality measures for groups reporting via the CMS Web Interface.*** CMS also clarifies here that groups reporting via the CMS Web Interface may also report the CAHPS for MIPS survey and receive bonus points for

submitting that measure.

- **CAHPS for MIPS Survey (p. 109)**
 - **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 and would end no later than February 28th following the applicable performance period** (as opposed to November to February, which has become operationally problematic for the administration of MIPS). CMS will further specify the start and end timeframes of the survey administration period through its normal communication channels.
 - **CMS 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.”** Neither of these measures have ever been scored measures within the Medicare Shared Savings Program CAHPS for Accountable Care Organizations (ACOs) Survey. CMS will review the findings of the CAHPS for ACO survey pilot, which was administered from November 2016 through February 2017 using a survey instrument which did not contain the two SSMs being proposed for removal from the CAHPS for MIPS survey. The remaining SSM in the CAHPS for MIPS survey would be:

Summary Survey Measures (SSMs)
Getting Timely Care, Appointments, and Information
How Well Providers Communicate
Patient's Rating of Provider
Access to Specialists
Health Promotion and Education
Shared Decision-Making
Health Status and Functional Status
Courteous and Helpful Office Staff
Care Coordination
Stewardship of Patient Resources

CMS also seeks comment on expanding, through future rulemaking, the patient experience data publicly available for the CAHPS for MIPS survey to include five open-ended questions. Currently, the CAHPS for MIPS survey data is available on Physician Compare and highly valued by patients and their caregivers. However, user testing revealed that users want more information from patients like them in their own words and requested that CMS include narrative reviews of individual clinicians and groups on the website. AHRQ is fielding a beta version of the [CAHPS Patient Narrative Elicitation Protocol](#), which includes five open-ended questions designed to be added to the CG CAHPS survey that capture patient narratives in a scientifically grounded and rigorous way, setting it apart from other patient narratives collected by various health systems and patient rating sites. CMS anticipates reviewing the results of current testing in collaboration with AHRQ before proposing changes to the CAHPS for MIPS survey.

CMS also seeks comments on ways to assign and sample patients using data from other payers. Since the CAHPS for MIPS survey currently relies on sampling protocols based on Medicare Part B billing, only Medicare Part B beneficiaries are sampled through that methodology. CMS seeks comment on the challenges groups may anticipate in trying to provide this type of information, especially for vulnerable beneficiary populations, such as those lacking stable housing. It also seeks comment on EHR vendors’ ability to provide information on the patients who receive care from their client groups.

Data Completeness Criteria (p. 113)

Concerned about the unintended consequences of accelerating the data completeness threshold too quickly,

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.

As in the past, those clinicians who utilize a QCDR, qualified registry, or EHR submission must contain a minimum of one quality measure for at least one Medicare patient.

As discussed in the [scoring section of this rule](#), for 2018, **CMS also proposes that MIPS eligible clinicians would receive 1 point for measures that fall below the data completeness threshold (rather than 3 points), with an exception for small practices of 15 or fewer who would still receive 3 points for measures that fail data completeness.**

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

Performance Period	Clinician Type	Submission Mechanism	Submission criteria	Data completeness
Jan 1–Dec 31	Individual MIPS eligible clinicians	Part B Claims	Report at least six measures including one outcome measure, or if an outcome measure is not available report another high priority measure; if less than six measures apply then report on each measure that is applicable. Individual MIPS eligible clinicians would have to select their measures from either the set of all MIPS measures listed or referenced in Table A or one of the specialty measure sets listed in Table B of the Appendix in this proposed rule.	50% of individual MIPS eligible clinician’s Medicare Part B patients for the performance period.
Jan 1–Dec 31	Individual MIPS eligible clinicians, groups or virtual groups	QCDR, Qualified Registry, & EHR	Report at least six measures including one outcome measure, or if an outcome measure is not available report another high priority measure; if less than six measures apply then report on each measure that is applicable. Individual MIPS eligible clinicians, groups, or virtual groups would have to select their measures from either the set of all MIPS measures listed or referenced in Table A or one of the specialty measure sets listed in Table B of the Appendix in this proposed rule.	50% of individual MIPS eligible clinician’s, group’s, or virtual group’s patients across all payers for the performance period.
Jan 1–Dec 31	Groups or virtual	CMS Web Interface	Report on all measures included in the CMS Web Interface; AND populate data fields for the first 248 consecutively ranked and assigned Medicare	Sampling requirements for

	groups		beneficiaries in the order in which they appear in the group's or virtual group's sample for each module/measure. If the pool of eligible assigned beneficiaries is less than 248, then the group or virtual group would report on 100% of assigned beneficiaries.	the group's or virtual group's Medicare Part B patients.
Jan 1–Dec 31	Groups or virtual groups	CAHPS for MIPS Survey	CMS-approved survey vendor would need to be paired with another reporting mechanism to ensure the minimum number of measures is reported. CAHPS for MIPS survey would fulfill the requirement for one patient experience measure towards the MIPS quality data submission criteria. CAHPS for MIPS survey would only count for one measure under the quality performance category.	Sampling requirements for the group's or virtual group's Medicare Part B patients.

Application of Quality Measures to Non-Patient Facing MIPS Eligible Clinicians (p. 118)

CMS does not propose any changes to this policy. 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.

Global and Population-Based Measures (p. 119)

CMS does not propose any changes to the use of the all-cause hospital readmissions (ACR) measure. CMS would continue to automatically calculate it for groups 16 or more who meet the case volume of 200 cases. This policy would also apply to virtual groups.

Selection of MIPS Quality Measures for Individual MIPS Eligible Clinicians and Groups Under the Annual List of Quality Measures Available for MIPS Assessment (p. 121)

In this section, CMS reviews its ongoing policies and process related to its annual Call for Measures and Measure Selection Process.

CMS requests that stakeholders apply the following considerations when submitting 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 complete 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.
- 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 likely to reject measures that do not provide substantial evidence of variation in performance. It also is likely to reject measures that are not outcome-based 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.

CMS reminds readers that it previously established that it would post the quality measures for use by QCDRs by no later than January 1 for performance periods occurring in 2018 and future years.

Proposed Measures

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 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.

Topped Out Measures ([p. 128](#))

CMS noted in the 2017 final rule that it would remove topped out measures over time. Based on feedback received, *CMS proposes a 3-year timeline for identifying 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.* This proposal applies to MIPS quality measures. QCDR measures that consistently are identified as topped out according to this same timeline, would not be approved for use in year 4 during the QCDR self-nomination review process.

CMS proposes to phase in this policy starting with a select set of six highly topped out measures identified in the [scoring section](#) of this rule. In that same section, CMS proposes to phase in special scoring for measures identified as topped out in the published benchmarks for two consecutive performance periods, starting with the select set of highly topped out measures for the 2018 MIPS performance period.

An example illustrating this proposed timeline for the removal and special scoring of topped out measures, as it would be applied to the select set of highly topped out measure, is included below:

- Year 1: The measures are identified as topped out in the benchmarks published for the 2017 MIPS performance Period. The 2017 benchmarks are posted on the [QPP website](#).
- Year 2: Measures are identified as topped out in the benchmarks published for the 2018 MIPS performance period.

- Year 3: Measures are identified as topped out in the benchmarks published for the 2019 MIPS performance period. The measures identified as topped out in the benchmarks published for the 2019 MIPS performance period and the previous two consecutive performance periods would continue to have special scoring applied for the 2019 MIPS performance period and would be considered, through notice-and-comment rulemaking, for removal for the 2020 MIPS performance period.
- Year 4: Topped out measures that are finalized for removal are no longer available for reporting. For example, the measures in the set of highly topped out measures identified as topped out for the 2017, 2018 and 2019 MIPS performance periods, and if subsequently finalized for removal will not be available on the list of measures for the 2020 MIPS performance period and future years.

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. If the measure benchmark is not topped out during one of the three 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 seeks comments on the above proposed timeline, specifically regarding the number of years before a topped out measure is identified and considered for removal, and under what circumstances it should remove topped out measures once they reach that point (e.g., should it be automatic removal or should CMS consider certain criteria?). CMS also seeks comment on whether topped out SSMs should be considered for removal from the CAHPS for MIPS Clinician or Group Survey measure due to high, unvarying performance within the SSM, or whether there is another alternative policy that could be applied for topped out SSMs.

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. However, the [scoring section of this rule](#) discusses policies regarding topped out measures from the CMS Web Interface.

Non-Outcome Measures ([p. 132](#))

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. CMS intends to revisit this issue and make proposals in future rulemaking.

Quality Measures Determined to be Outcome Measures ([p. 133](#))

CMS currently uses the following as a basis to determine if a measure is considered an outcome measure:

- Measure Steward and National Quality Forum (NQF) designation – For most measures, CMS uses the designation as determined by the measure steward and the measure’s NQF designation to determine if it is an outcome measure or not. If not clear, CMS will use the next step.
- Utilization of the [CMS Blueprint](#) definitions for outcome measures. An outcome of care is a health state of a patient resulting from health care. Outcome measures are supported by evidence that the measure has been used to detect the impact of one or more clinical interventions. Clinical analysts are utilized to evaluate the measure.

CMS seeks comment on its current criteria and process, outlined in this section, for designating outcome measures. Specifically, are there additional criteria it should take into consideration when determining if a measure meets the criteria of an outcome measure? Should CMS use different criteria for MIPS measures versus QCDR measures?

Cost Performance Category (p. 135)

In the 2017 QPP final rule, CMS finalized a cost performance category weight of 10% for the 2020 MIPS payment year. For the 2021 MIPS payment year and beyond, CMS finalized a weight of 30% for the cost 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.*** CMS continues to have concerns about the level of familiarity and understanding of cost measures among clinicians and hopes to use this additional year to increase understanding of the measures so that clinicians will be more comfortable with their role in reducing costs for their patients. CMS also will use this additional year to develop more episode-based measures, which it intends to propose in future rulemaking.

CMS reminds readers that section 1848(q)(5)(E)(i)(II)(aa) of the Act requires it to assign a weight of 30% to the cost category beginning in the 2021 MIPS payment year. CMS recognizes that its decision to assign cost a 0% weight for the 2020 payment year may not provide a smooth enough transition for integrating cost measures into MIPS in the 2021 payment year and may not provide enough encouragement to clinicians to review their performance on cost measures. Therefore, ***CMS also seeks comment on keeping the weight of the cost performance category at 10% for the 2020 MIPS payment year.***

Total Per Capita Cost and MSPB Measures (p. 139)

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. CMS proposes to continue to calculate these two measures because of clinician familiarity with them, because they cover a large number of patients, and because they provide an important measurement of clinician contribution to the overall population that a clinician encounters.

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.

Episode-Based Measures (p. 140)

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 instead will work to develop new episode-based measures, with significant clinician input, for future performance periods.

Throughout the cost section of this rule, CMS reminds readers of its ongoing work with relevant clinical stakeholders related to the development of episode-based cost measures and patient condition groups and codes. CMS is currently reviewing feedback received in response to its December 2016 posting titled "[Episode-Based Cost Measure Development for the Quality Program](#)," and will share plans to work with clinicians on the further developments of these proposals in the future. Section 1848(r)(2)(G) of the Act requires that CMS post an operational list of care episode and patient condition groups in December 2017. Section 1848(r)(2)(H) of the Act also requires that not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, revise the operational list as the Secretary determines may be appropriate.

CMS also reviews here the history of its work with clinical stakeholders to develop episode-based cost measures, including the recent convening of Clinical Committees to identify conditions and procedures for episode groups and to determine which services or claims would be counted in episode costs. ***CMS notes that this process remains open to additional individuals.*** Although there was clinician involvement in the development of some of the episode-based measures included for the 2017 MIPS performance period, it was not as extensive as the process CMS is currently using, which was implemented in response to overwhelming stakeholder interest in the need for more clinician involvement. CMS believes that the new episode-based measures, which it intends to propose in future rulemaking, will be substantially improved by more extensive stakeholder feedback and involvement in the process. As this process continues, CMS continues to seek input from clinicians and aims to have as many episode-based measures available as possible for the proposed 2019 MIPS performance period.

Although CMS does not propose to include any episode-based measures in calculating the cost performance category score for the 2020 MIPS payment year, it does plan 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. Because these measures will be generated based on claims data like other cost measures, CMS will not collect any additional data from clinicians.

CMS aims to provide an initial opportunity for clinicians to review their performance based on the new episode-based measures currently under development at some point in the fall of 2017, as the measures and other information is available, and then additional feedback around summer 2018. This feedback will go to those MIPS eligible clinicians for whom CMS is able to calculate the episode-based measures, which means it would be possible that a clinician may not receive feedback on episode-based measures in both the fall of 2017 and the summer of 2018. This feedback may be presented in a different format than MIPS performance feedback described later in this rule. However, its CMS' intention to align feedback as much as possible.

Because CMS is focusing on development of new episode-based measures, its feedback on episode-based measures that were previously developed will discontinue after 2017 to avoid confusion.

Attribution (p. 144)

In the 2017 QPP final rule, CMS changed the list of primary care services that had been used to determine attribution for the total per capita cost measure by adding transitional care management (CPT codes 99495 and 99496) codes and a chronic care management code (CPT code 99490) (81 FR 77169). In the 2017 Physician Fee Schedule final rule, it changed the payment status for two existing CPT codes (CPT codes 99487 and 99489) that could be used to describe care management from B (bundled) to A (active) meaning that the services would be paid under the Physician Fee Schedule (81 FR 80349). The services described by these codes are substantially similar to those described by the chronic care management code that CMS added to the list of primary care services beginning with the 2017 performance period. Thus, **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.**

CMS does not propose any changes to the attribution methods for the MSPB measure and refers readers to the 2017 QPP final rule (81 FR 77168 through 77169) for more information.

Reliability (p. 145)

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 does not propose any adjustments to its reliability policies.** However, CMS understands and appreciates concerns that have been expressed about reliability of measures, and will continue to evaluate reliability as it develops new measures to ensure that they meet an appropriate standard. CMS notes its desire for strong reliability, but not at the expense of losing valuable information about clinicians. Similarly, CMS is concerned that placing too much of an emphasis on reliability calculations could limit the applicability of cost measures to large group practices who, by nature of their size, have larger patient populations, thus depriving solo clinicians and individual reporters from being rewarded for efforts to better manage patients.

Attribution for Individuals and Groups (p. 147)

CMS does not propose any changes for how it attributes cost measures to individual and group reporters.

Incorporation of Cost Measures with SES or Risk Adjustment (p. 147)

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 (such as age) or certain clinical conditions. CMS recognizes that the risks accounted for with this adjustment are not the only potential attributes that could lead to a higher cost patient. Stakeholders have pointed to many other factors such as

income level, race, and geography that they believe contribute to increased costs. These issues and CMS' plans for attempting to address them are discussed [later in this rule](#).

Incorporation of Cost Measures with ICD-10 Impacts (p. 148)

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 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. However, CMS recognizes that as it continues to expand cost measures, episode-based measures may be opened (triggered) by and may assign services based on ICD-10 codes. CMS clarifies that changes to ICD-10 codes will be incorporated into the measure specifications on a regular basis through the measure maintenance process.

Application of Measures to Non-Patient Facing MIPS Eligible Clinicians (p. 148)

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. CMS anticipates that many non-patient facing MIPS eligible clinicians may not have sufficient cost measures applicable and available to them and would not be scored on the cost performance category under MIPS. ***CMS continues to consider opportunities to develop alternative cost measures for non-patient facing clinicians and solicits comment on this topic to inform our future rulemaking.***

Facility-Based Measurement as it Relates to the Cost Performance Category

[Later in 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. This discussion includes the measures that would be used and how they would be scored for the cost performance category.

Improvement Activity Criteria (p. 150)

Background (p. 150)

CMS previously defined improvement activities at §414.1305 as an activity that relevant MIPS eligible clinicians, organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

CMS previously solicited comments on activities that would advance the usage of health IT to support improvement activities. While some commenters were supportive, others expressed concern about health IT-associated burdens and costs, and recommended that CMS offer diverse activities that do not rely on emerging capabilities of certified health IT and that it be less prescriptive in health IT requirements.

Many of the proposed new improvement activities in [Table F](#), and in [Table H: Finalized Improvement Activities Inventory](#) that were finalized in the 2017 QPP final rule, emphasize the use of health IT. CMS previously finalized a policy to allow MIPS eligible clinicians to achieve a bonus in the ACI performance category when they use functions included in CEHRT to complete eligible activities from the Improvement Activities Inventory. ***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.***

Contribution to Final Score (p. 152)

CMS previously finalized at §414.1355 that the improvement activities performance category would account for 15% of the final score. At §414.1380(b)(3)(iv), CMS finalized criteria for recognition as a certified-patient centered medical home or comparable specialty practice. However, it has come to CMS' attention that the common terminology utilized in the general medical community for "certified" patient-centered medical home is "recognized" patient-centered medical home. To provide clarity, ***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 previously requested commenters’ specific suggestions for additional activities or activities that may merit additional points beyond the “high” level. Commenters provided a wide-range of options, and in response, **CMS proposes new, high-weighted activities in Table F.** CMS continues to believe that high weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being. As such, CMS does not propose changes to this approach; however, **CMS will take suggested additional criteria into consideration for designating high-weighted activities in future rulemaking.**

Improvement Activities Data Submission Criteria (p. 154)

Submission Mechanisms. CMS previously allowed for submission of data for the improvement activities performance category using the qualified registry, EHR, QCDR, CMS Web Interface, and attestation data submission mechanisms through attestation. In addition, regardless of the data submission method, with the exception of MIPS eligible clinicians in MIPS APMs, all individual MIPS eligible clinicians or groups must select activities from the Improvement Activities Inventory. CMS also finalized at §414.1360 that for the transition year of MIPS, all individual MIPS eligible clinicians or groups, or third party intermediaries such as health IT vendors, QCDRs and qualified registries that submit on behalf of an individual MIPS eligible clinician or group, must designate a “yes” response for activities on the Improvement Activities Inventory. In the case where an individual MIPS eligible clinician or group is using a health IT vendor, QCDR, or qualified registry for their data submission, the individual MIPS eligible clinician or group will certify all improvement activities were performed and the health IT vendor, QCDR, or qualified registry would submit on their behalf. To maintain stability in the QPP, **CMS proposes to continue this policy into future years and proposes to modify the regulatory text at §414.1360 to reflect this.** In addition, as discussed in elsewhere in this summary, **CMS proposes to generally apply its previously finalized and proposed group policies to virtual groups.**

In addition, CMS previously finalized at §414.1325(d) that individual MIPS eligible clinicians and groups may only use one submission mechanism per performance category. **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.** See elsewhere in this summary for further discussion of this proposal.

In future updates to the Improvement Activities Inventory, CMS intends to continue to indicate which activities qualify for the ACI performance category bonus.

CMS previously clarified that if one MIPS eligible clinician (NPI) in a group completed an improvement activity, the entire group (TIN) would receive credit for that activity. In addition, CMS specified that all MIPS eligible clinicians reporting as a group would receive the same score for the improvement activities performance category if at least one clinician within the group is performing the activity for a continuous 90 days in the performance period. As discussed elsewhere in this summary, **CMS proposes to generally apply its previously finalized and proposed group policies to virtual groups. 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.**

Additionally, CMS previously noted that it intended, in future years, to score the improvement activities performance category based on performance and improvement, rather than simple attestation. ***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.***

Submission Criteria. CMS previously finalized at §414.1380 to set the improvement activities submission criteria under MIPS, to achieve the highest potential score, at two high-weighted improvement activities or four medium-weighted improvement activities, or some combination of high and medium-weighted improvement activities. While the minimum reporting period for one improvement activity is 90 days, the maximum frequency with which an improvement activity may be reported would be once during the 12-month performance period. In addition, as discussed elsewhere in this summary, ***CMS proposes to generally apply its previously finalized and proposed group policies to virtual groups.***

CMS established exceptions to the above for: small practices; practices located in rural areas; practices located in geographic HPSAs; non-patient facing individual MIPS eligible clinicians or groups; and individual MIPS eligible clinicians and groups that participate in a MIPS APM or a patient-centered medical home submitting in MIPS. Specifically, for individual MIPS eligible clinicians and groups that are small practices, practices located in rural areas or geographic HPSAs, or non-patient facing individual MIPS eligible clinicians or groups, to achieve the highest score, one high-weighted or two medium-weighted improvement activities are required. For these individual MIPS eligible clinicians and groups, in order to achieve one-half of the highest score, one medium-weighted improvement activity is required.

Under the APM scoring standard, all clinicians identified on the Participation List of an APM receive at least one-half of the highest score applicable to the MIPS APM. If the MIPS APM does not receive the maximum improvement activities performance category score then the APM entity can submit additional improvement activities. All other individual MIPS eligible clinicians or groups that CMS identifies as participating in APMs that are not MIPS APMs will need to select additional improvement activities to achieve the improvement activities highest score. See elsewhere in this summary for further discussion of the APM scoring standard.

As required by statute, CMS provides full credit for the improvement activities performance category for an individual MIPS eligible clinician or group that has received certification or accreditation as a patient-centered medical home or comparable specialty practice from a national program or from a regional or state program, private payer or other body that administers patient-centered medical home accreditation and certifies 500 or more practices for patient-centered medical home accreditation or comparable specialty practice certification, or for an individual MIPS eligible clinician or group that is a participant in a medical home model.

Practices may receive this designation at a practice level and TINs may be comprised of both undesignated practices and designated practices. CMS finalized at §414.1380(b)(3)(viii) that to receive full credit as a certified patient-centered medical home or comparable specialty practice, a TIN that is reporting must include at least one practice that is a certified patient-centered medical home or comparable specialty practice. CMS also indicated that it would continue to have more stringent requirements in future years, and would lay the groundwork for expansion towards continuous improvement over time. Accordingly, ***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.*** If the group is unable to meet the 50% threshold then the individual MIPS eligible clinician may choose to receive full credit as a certified patient-centered medical home or comparable specialty practice by reporting as an individual for all performance categories. In addition, as discussed elsewhere in this summary, ***CMS proposes to generally apply its previously finalized and proposed group policies to virtual groups.*** 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 has also determined that the Comprehensive Primary Care Plus (CPC+) APM design satisfies the requirements to be designated as a medical home model, as defined in §414.1305, and is therefore a certified or recognized patient-centered medical home for purposes of the improvement activities performance category. Accordingly, **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.** MIPS eligible clinicians who attest that they are in practices that have been randomized to the control group in the CPC+ APM would receive full credit for the improvement activities performance category for each performance period in which they are on the Practitioner Roster, the official list of eligible clinicians participating in a practice in the CPC+ control group. **CMS requests comments on these proposals.**

Required Period of Time for Performing an Activity. CMS previously specified at §414.1360 that MIPS eligible clinicians or groups must perform improvement activities for at least 90 consecutive days during the performance period for improvement activities performance category credit. Activities, where applicable, may be continuing (that is, could have started prior to the performance period and are continuing) or be adopted in the performance period as long as an activity is being performed for at least 90 days during the performance period. In addition, as discussed elsewhere in this summary, **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.**

Application of Improvement Activities to Non-Patient Facing Individual MIPS Eligible Clinicians and Groups (p. 161)

CMS previously specified at §414.1380(b)(3)(vii) that for non-patient facing individual MIPS eligible clinicians or groups, to achieve the highest score one high-weighted or two medium-weighted improvement activities are required. For these individual MIPS eligible clinicians and groups, in order to achieve one-half of the highest score, one medium-weighted improvement activity is required. **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.**

Special Consideration for Small, Rural, or Health Professional Shortage Areas Practices (p. 161)

CMS previously finalized at §414.1380(b)(3)(vii) that one high-weighted or two medium-weighted improvement activities are required for individual MIPS eligible clinicians and groups that are small practices or located in rural areas, or geographic HPSAs, to achieve full credit. In addition, CMS specified at §414.1305 that a rural area means ZIP codes designated as rural, using the most recent HRSA Area Health Resource File data set available. Lastly, CMS finalized the following definitions at §414.1305:

- (1) small practices is defined to mean practices consisting of 15 or fewer clinicians and solo practitioners; and
- (2) Health Professional Shortage Areas (HPSA) refers to areas as designated under section 332(a)(1)(A) of the Public Health Service Act.

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.

Improvement Activities Subcategories (p. 162)

CMS previously finalized at §414.1365 that the improvement activities performance category will include the subcategories of activities provided at section 1848(q)(2)(B)(iii) of the Act. In addition, CMS finalized at §414.1365 the following additional subcategories:

- Achieving Health Equity;
- Integrated Behavioral and Mental Health; and
- Emergency Preparedness and Response.

CMS does not propose any changes to the improvement activities subcategories for the improvement activities performance category in this proposed rule.

Improvement Activities Inventory ([p. 162](#))

Proposed Approach on the Annual Call for Activities Process for Adding New Activities. During this transition period, CMS received input from various MIPS eligible clinicians and organizations suggesting possible new activities via a nomination form that was posted on the CMS website. ***CMS proposes new activities and changes to the Improvement Activities Inventory in [Tables F](#) and [G](#) of this proposed rule.***

For the QPP Year 3 and future years, ***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.*** Individual MIPS eligible clinicians and groups and relevant stakeholders would be able to provide an explanation via the nomination form of how the improvement activity meets all of CMS' criteria (see below). ***CMS requests comment on this proposed annual Call for Activities process.***

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 of the following criteria when submitting improvement activities in response to the Annual Call for Activities:***

- 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;
- Activities that may be considered for an ACI 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, 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.

Activities that overlap with other performance categories may be included if such activities support the key goals of the program. ***CMS requests comments on this proposal.***

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.*** This list will be considered by CMS and may include federal partners in collaboration with stakeholders. The IAUR list will be analyzed with consideration of the proposed criteria for inclusion of improvement activities in the Improvement Activities Inventory. In addition, ***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,*** which is slightly different than the Call for Measures timeline. ***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.

Approach for Adding New Subcategories (p. 165)

CMS previously finalized the following criteria for adding a new subcategory to the improvement activities performance category:

- The new subcategory represents an area that could highlight improved beneficiary health outcomes, patient engagement and safety based on evidence.
- The new subcategory has a designated number of activities that meet the criteria for an improvement activity and cannot be classified under the existing subcategories.
- Newly identified subcategories would contribute to improvement in patient care practices or improvement in performance on quality measures and cost performance categories.

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.

Stakeholders have suggested that a separate subcategory for improvement activities specifically related to health IT would make it easier for MIPS eligible clinicians and vendors to understand and earn points toward their final score through the use of health IT. **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. 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 Study on Burdens Associated with Reporting Quality Measures (p. 167)

CMS previously finalized specifics regarding the CMS Study on Improvement Activities and Measurement including the study purpose, study participation credit and requirements, and the study procedure. In this proposed rule, **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**, to assess clinician burden and data submission errors associated with the collection and submission of clinician quality measures for MIPS.

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 already intended to perform descriptive statistics to compare the trends in errors and burden between study years 2017 and 2018, but it would also like to perform a more rigorous statistical analysis with the 2018 data, which will require a larger sample size. CMS proposes this increase in the sample size for 2018 to provide the minimum sample needed to get a significant result with adequate power for the following investigation.

Specifically, CMS is interested in whether there are any significant differences in quality measurement data submission errors and/or clinician burdens between rural clinicians submitting either individually or as a group, and urban clinicians submitting as an individual or as a group. A statistical power analysis was performed and a total sample size of 118 will be adequate for the main objective of the study. However, allowance will be made to account for attrition and other additional (or secondary) analysis.

This analysis would be compared at different sizes of practices (< 3 eligible clinicians, between 3-8 eligible clinicians, etc.). This assessment is important since it facilitates tracing the root causes of measurement burdens

and data submission errors that may be associated with any sub-group of clinician practice. This comparison may further break the sample down into more than four categories and a much larger sample size is a requisite for significant results with adequate probability of certainty.

The sample size for performance periods occurring in 2017 consisted of 42 MIPS groups as stated by MIPS criteria from the following seven categories:

- 10 urban individual or groups of < 3 eligible clinicians.
- 10 rural individual or groups of < 3 eligible clinicians.
- 10 groups of 3-8 eligible clinicians.
- 5 groups of 8-20 eligible clinicians.
- 3 groups of 20-100 eligible clinicians.
- 2 groups of 100 or greater eligible clinicians.
- 2 specialty groups.

CMS proposes to increase the sample size for the performance periods occurring in 2018 to a minimum of:

- 20 urban individual or groups of < 3 eligible clinicians, - (broken down into 10 individuals & 10 groups).
- 20 rural individual or groups of < 3 eligible clinicians - (broken down into 10 individuals & 10 groups).
- 10 groups of 3-8 eligible clinicians.
- 10 groups of 8-20 eligible clinicians.
- 10 groups of 20-100 eligible clinicians.
- 10 groups of 100 or greater eligible clinicians.
- 6 groups of > 20 eligible clinicians reporting as individuals - (broken down into 3 urban & 3 rural).
- 6 specialty groups - (broken down into 3 reporting individually & 3 reporting as a group).
- Up to 10 non-MIPS eligible clinicians reporting as a group or individual (any number of individuals and any group size).

In addition, CMS proposes changes to the study procedures. All study participants would participate in surveys and focus group meetings at least once after each measures data submission. For those who elect to report data for a 90-day period, CMS would make further engagement optional. Therefore, ***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.

Advancing Care Information (ACI) Performance Category ([p. 172](#))

Scoring ([p. 172](#))

MACRA requires that 25% of the MIPS final score is based on performance for the ACI performance category. CMS previously established at §414.1380(b)(4) that the score for the ACI performance category would be comprised of a base score, performance score, and potential bonus points for reporting on certain measures and activities.

Base Score. CMS does not propose any changes to the base score methodology.

Performance Score. CMS does not propose to change the maximum performance score that a MIPS eligible clinician can earn; it remains at 90%. However, CMS proposes to modify the scoring of the Public Health and Clinical Data Registry Reporting objective beginning with the performance period in 2018, given there are areas of the country where immunization registries are not available, which disadvantages MIPS eligible clinicians practicing in those areas. **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).** A MIPS eligible clinician who chooses to report to more than one public health agency or clinical data registry may receive credit in the performance score for the submission to more than one agency or registry; however, the MIPS eligible clinician would not earn more than a total of 10 percentage points for such reporting.

Bonus Score. For the Public Health and Clinical Data Registry Reporting objective and the Public Health Reporting objective, CMS previously finalized that MIPS eligible clinicians who report to one or more public health agencies or clinical data registries beyond the Immunization Registry Reporting Measure will earn a bonus score of 5 percentage points in the ACI performance category. Given the aforementioned modifications proposed for the performance 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.** That is, a MIPS eligible clinician would not receive credit under both the performance score and bonus score for reporting to the same agency or registry.

Specifically, **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.

Improvement Activities Bonus Score under the ACI Performance Category. CMS previously adopted a policy to award a 10% bonus for the ACI performance category if a MIPS eligible clinician attests to completing at least one of the improvement activities using CEHRT. **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 score if they are completed using CEHRT functionality.** The activities eligible for the bonus score would include those listed in [Table 6](#), as well as those listed in [Table 8 in the 2017 QPP final rule](#). Ten percentage points is the maximum bonus a MIPS eligible clinician would receive if they attest to using CEHRT for one or more of the activities CMS has identified as eligible for the bonus. **CMS invites comment on this proposal.**

Performance Periods for the ACI Performance Category ([p. 181](#))

CMS previously established a performance period for the ACI performance category to align with the overall MIPS performance period of one full year to ensure all four performance categories are measured and scored based on the same period of time. CMS stated for the first and second performance periods of MIPS (CYs 2017 and 2018) it would accept a minimum of 90 consecutive days of data and encourage MIPS eligible clinicians to

report data for the full year performance period. CMS is maintaining this policy as finalized for the performance period in CY 2018, and will accept a minimum of 90 consecutive days of data in 2018. ***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.*** See elsewhere in this summary for additional information on the MIPS performance period.

Certification Requirements (p. 182)

CMS previously finalized that MIPS eligible clinicians must use EHR technology certified to the 2015 Edition for the 2018 performance period. However, in light of the conservative readiness estimates for MIPS eligible clinicians, and in line with CMS' commitment to supporting small practices, solo practitioners and specialties which may be more likely to use certified health IT offered by small developers, ***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.***

In addition, to encourage new participants to adopt certified health IT and to incentivize participants to upgrade their technology to 2015 Edition products, ***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 proposes this one-time bonus for 2018 to support and recognize MIPS eligible clinicians and groups that invest in implementing certified EHR technology in their practice. ***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.*** This bonus is not available to MIPS eligible clinicians who use a combination of the 2014 and 2015 Editions. With the addition of the 2015 Edition CEHRT bonus of 10 percentage points, MIPS eligible clinicians would be able to earn a bonus score of up to 25 percentage points in 2018 under the ACI performance category, an increase from the 15-percentage point bonus score available in 2017.

See [Table 8](#) for the ACI Objectives and Measures and certification criteria required to meet the objectives and measures. ***CMS invites comments on these proposals.***

Scoring Methodology Considerations (p. 188)

As noted above, MACRA states that 25% of the MIPS final score shall be based on performance for the ACI performance category. MACRA also provides that in any year in which the Secretary estimates that the proportion of eligible professionals (as defined in section 1848(o)(5) of the Act¹) who are meaningful EHR users (as determined under section 1848(o)(2) of the Act) is 75% or greater, the Secretary may reduce the applicable percentage weight of the ACI performance category in the MIPS final score, but not below 15%, and increase the weightings of the other performance categories such that the total percentage points of the increase equals the total percentage points of the reduction.

CMS previously established a final policy to estimate the proportion of physicians² who are meaningful EHR users as those physician MIPS eligible clinicians who earn an ACI performance category score of at least 75% for a performance period. The earliest CMS would be able to make its estimation based on 2017 data and propose in future rulemaking to change the weight of the ACI performance category for the 2019 MIPS payment year would be mid-2018, as the deadline for data submission is March 31, 2018. CMS is concerned that, if it were to make a change via rulemaking, this could cause confusion to MIPS eligible clinicians who are adjusting to the MIPS program and believe this performance category will make up 25% of the final score for the 2019 MIPS payment year. ***CMS requests public comments on whether this timeframe is sufficient, or whether a more extended timeframe would be preferable.***

¹ Section 1848(o)(5) of the Act defines an eligible professional as a physician, as defined in section 1861(r) of the Act.

² See section 1861(r) of the Act

Given the aforementioned concern, **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.** Under this scenario, CMS would use data from the 2017 performance period to estimate the proportion of physicians who are meaningful EHR users for purposes of reweighting the ACI performance category for the 2021 MIPS payment year.

Objectives and Measures (p. 190)

Advancing Care Information Objectives and Measures Specifications. CMS proposes to maintain for the 2018 performance period the Advancing Care Information Objectives and Measures as finalized in the 2017 QPP final rule with the modifications proposed, which is outlined in [Appendix A](#) of this summary. [Table 7](#), which is below, outlines the 2018 performance period ACI performance category scoring methodology for the ACI objectives and measures.

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

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

performance score		
Report improvement activities using CEHRT	10% bonus	Yes/No Statement
Report using only 2015 Edition CEHRT	10% bonus	Based upon measures submitted

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

CMS has split the Specialized Registry Reporting Measure that it adopted under the 2017 Advancing Care Information Transition Objectives and Measures into two separate measures – Public Health Registry and Clinical Data Registry Reporting – to better define the registries available for reporting. **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.** A MIPS eligible clinician may count a specialized registry if the MIPS eligible clinician achieved the phase of active engagement as described under “active engagement option 3: production” in the 2015 EHR Incentive Programs final rule with comment period, meaning the clinician has completed testing and validation of the electronic submission and is electronically submitting production data to the public health agency or clinical data registry.

[Table 8](#) includes the 2015 Edition and 2014 Edition certification criteria required to meet the 2018 ACI objectives and measures.

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. [Table 9](#), which is below, outlines the 2018 performance period ACI performance category scoring methodology for the ACI transition objectives and measures.

**[TABLE 9](#): 2018 Performance Period Advancing Care Information Performance Category Scoring Methodology
Advancing Care Information Transition Objectives and Measures**

2018 ACI Transition Objective	2018 ACI Transition Measure	Required/ Not Required for Base Score (50%)	Performance Score (up to 90%)	Reporting Requirements
Protect Patient Health Information	Security Risk Analysis	Required	0	Yes/No Statement
Electronic Prescribing	e-Prescribing	Required	0	Numerator/Denominator
Patient Electronic Access	Provide Patient Access	Required	Up to 20%	Numerator/Denominator
	View, Download, or Transmit	Not Required	Up to 10%	Numerator/Denominator
Patient-Specific Education	Patient-Specific Education	Not Required	Up to 10%	Numerator/Denominator
Secure Messaging	Secure Messaging	Not Required	Up to 10%	Numerator/Denominator
Health Information Exchange	Health Information Exchange	Required	Up to 20%	Numerator/Denominator
Medication Reconciliation	Medication Reconciliation	Not Required	Up to 10%	Numerator/Denominator

Public Health Reporting	Immunization Registry Reporting	Not Required	0 or 10%	Yes/No Statement
	Syndromic Surveillance Reporting	Not Required	0 or 5%*	Yes/No Statement
	Specialized Registry Reporting	Not Required	0 or 5%*	Yes/No Statement
Bonus (up to 15%)				
Report to one or more additional public health agencies or clinical data registries beyond those identified for the performance score		5% bonus		Yes/No Statement
Report improvement activities using CEHRT		10% bonus		Yes/No Statement

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

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). For the electronic prescribing objective and measure, MIPS eligible clinicians who wish to claim the exclusion would select “yes” to the exclusion and submit a null value for the measure, thereby fulfilling the requirement to report this measure as part of the base score. It is important that a MIPS eligible clinician actually claims the exclusion if they wish to exclude the measure. Otherwise, they would fail the measure and not earn a base score or any score in the ACI performance category.

Additional Considerations ([p. 214](#))

21st Century Cures Act. The 21st Century Cures Act (Pub. L. 114-255), which was enacted on December 13, 2016, amended section 1848(o)(2)(D) of the Act to state that the provisions of sections 1848(a)(7)(B) and (D) of the Act shall apply to assessments of MIPS eligible clinicians under section 1848(q) of the Act with respect to the performance category described in subsection (q)(2)(A)(iv) (the ACI performance category) in an appropriate manner which may be similar to the manner in which such provisions apply with respect to the meaningful use payment adjustment made under section 1848(a)(7)(A) of the 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.

MIPS Eligible Clinicians Facing a Significant Hardship. For MIPS eligible clinicians facing a significant hardship, such as those who lack sufficient internet connectivity, face extreme and uncontrollable circumstances, lack control over the availability of CEHRT, or do not have face-to-face interactions with patients, **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.** While the agency proposes to rely on a new statutory authority to provide hardship exceptions, it would continue to assign a 0% weighting to the ACI performance category in the MIPS final score for a MIPS payment year for MIPS eligible clinicians who successfully demonstrate a significant hardship using the categories of significant hardship and application process as previously established for the 2017 QPP. CMS would automatically reweight the ACI performance category to 0% for a MIPS eligible clinician who lacks face-to-face patient interaction and is classified as a non-patient facing MIPS eligible clinician without requiring an application.

However, if a MIPS eligible clinician submits an application for a significant hardship exception or is classified as a non-patient facing MIPS eligible clinician, but also reports on the measures specified for the ACI performance category, they would be scored on the ACI performance category like all other MIPS eligible clinicians, and the category would be given the weighting prescribed by section 1848(q)(5)(E) of the Act regardless of the MIPS eligible clinician’s score.

In addition, **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' 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. Given ongoing concerns about the impact of MACRA on small practices, **CMS proposes a significant hardship exception for the ACI performance category for MIPS eligible clinicians who are in small practices³ 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.** A MIPS eligible clinician seeking to qualify for this exception would submit an application in the form and manner specified by CMS by December 31 of the performance period or a later date specified by the agency. **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.** The exception would be subject to annual renewal, and the 5-year limitation would not apply to this significant hardship exception for MIPS eligible clinicians in small practices.

CMS is considering whether other categories or types of clinicians might similarly require an exception and solicits comment what those categories or types are, why such an exception is required, and any data available to support the necessity of the exception. Supporting data would be particularly helpful to CMS' consideration of whether any additional exceptions would be appropriate. **CMS seeks comments on these proposals.**

Hospital-Based MIPS Eligible Clinicians. CMS previously defined a hospital-based MIPS eligible clinician under §414.1305 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) codes used in the HIPAA standard transaction as an inpatient hospital (POS 21), on-campus outpatient hospital (POS 22), or emergency room (POS 23) setting, based on claims for a period prior to the performance period as specified by CMS. CMS intends 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 will use a 12-month period as close as practicable to this time period. CMS discussed its assumption that MIPS eligible clinicians who are determined hospital-based do not have sufficient ACI measures applicable to them, and it established a policy to reweight the ACI performance category to 0% of the MIPS final score for the MIPS payment year in accordance with section 1848(q)(5)(F) of the Act (81 FR 77240).

Given changes in the law made by the 21st Century Cures Act noted above, **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 would continue to assign a 0% weighting to the ACI performance category in the MIPS final score for a MIPS payment year for hospital-based MIPS eligible clinicians as previously defined. A hospital-based MIPS eligible clinician would have the option to report the ACI measures for the performance period for the MIPS payment year for which they are determined hospital-based. However, if a MIPS eligible clinician who is determined

³ Small practices are defined under §414.1305 as 15 or fewer clinicians and solo practitioners

hospital-based chooses to report on the ACI measures, they would be scored on ACI performance category like all other MIPS eligible clinicians, and the category would be given the weighting prescribed by section 1848(q)(5)(E) of the Act regardless of their score.

CMS proposes to amend §414.1380(c)(1) and (2) of the regulation text to reflect this proposal, but requests comments on using section 1848(o)(2)(D) for exceptions for hospital-based MIPS eligible clinicians.

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

Aligning with the hospital-based MIPS eligible clinician policy, ***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 notes that the ASC-based determination will be made independent of the hospital-based determination.

To determine a MIPS eligible clinician’s ASC-based status, ***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 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 the 2019 MIPS payment year, CMS would not be able to notify MIPS eligible clinicians of their ASC-based status until after the final rule is published, which CMS anticipates would be later in 2017, and would be accomplished via the website, QPP.cms.gov.

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. Section 4002(b)(1)(A) of the 21st Century Cures Act amended section 1848(a)(7)(B) of the Act to provide that the Secretary shall exempt an eligible professional from the application of the payment adjustment under section 1848(a)(7)(A) of the Act with

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

CMS proposes that a MIPS eligible clinician may demonstrate through an application process that reporting on the measures specified for the ACI performance 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. The exception would be subject to annual renewal, and in no case may a MIPS eligible clinician be granted an exception for more than 5 years. 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 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 previously defined a hospital-based MIPS eligible clinician as a MIPS eligible clinician who furnishes 0% or more of his or her covered professional services in sites of services identified by the Place of Service (POS) codes used in the HIPAA standard transaction as an inpatient hospital (POS 21), on campus outpatient hospital (POS 22) or emergency room (POS 23) setting, based on claims for a period prior to the performance period as specified by CMS.

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.

Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists. CMS previously established a policy under section 1848(q)(5)(F) of the Act to assign a weight of zero to the ACI performance category in the MIPS final score if there are not sufficient measures applicable and available to NPs, PAs, CRNAs, and CNSs. However, these clinicians will be scored on the ACI performance category like all other MIPS eligible clinicians and the ACI performance category will be given the weighting prescribed by section 1848(q)(5)(E) of the Act regardless of their ACI performance category score. ***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. In addition, through the [Call for Measures Process](#), CMS seeks new measures that may be more broadly applicable to these additional types of MIPS eligible clinicians in future program years.

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 notes that these MIPS eligible clinicians may choose to submit ACI measures; however, if they choose to report, they will be scored on the ACI performance category like all other MIPS eligible clinicians and the performance category will be given the weighting prescribed by section 1848(q)(5)(E) of the Act regardless of their ACI performance category score. This policy includes MIPS eligible clinicians choosing to report as part of a group practice or part of a virtual group.

Group practices as defined at §414.1310(e)(1) are required to aggregate their performance data across the TIN in order for their performance to be assessed as a group. Additionally, groups that elect to have their performance assessed as a group will be assessed as a group across all four MIPS performance categories. By reporting as part of a group practice, MIPS eligible clinicians are subscribing to the data reporting and scoring requirements of the group practice. CMS notes that the data submission criteria for groups reporting ACI performance category described in the 2017 QPP final rule state that group data should be aggregated for all MIPS eligible clinicians within the group practice. This includes those MIPS eligible clinicians who may qualify for a 0% weighting of the ACI performance category due to the circumstances as described above, such as a significant hardship or other type of exception, hospital-based or ASC-based status, or certain types of non-physician practitioners (NPs, PAs, CNSs, and CRNAs). If these MIPS eligible clinicians report as part of a group practice or virtual group, they will be scored on the ACI performance category like all other MIPS eligible clinicians and the performance category will be given the weighting prescribed by section 1848(q)(5)(E) of the Act regardless of the group practice's ACI performance category score.

Timeline for Submission of Reweighting Applications. CMS previously established the timeline for the submission of applications to reweight the ACI performance category in the MIPS final score to align with the data submission timeline for MIPS. The Quality Payment Program Exception Application will be used to apply for the following exceptions: Insufficient Internet Connectivity; Extreme and Uncontrollable Circumstances; Lack of Control over the Availability of CEHRT; Decertification of CEHRT; and Small Practice.

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 plans to have the application available in mid-2017. MIPS eligible clinicians are encouraged to apply early as CMS expects to process the applications on a rolling basis. If a MIPS eligible clinician submits data for the ACI category after an application has been submitted, the data would be scored, the application would be considered voided and the ACI performance category would not be reweighted.

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 deadline for the CY 2018 performance period, March 31, 2019.

APM Scoring Standard for MIPS Eligible Clinicians in MIPS APMs (p. 234)

Under section 1848(q)(1)(C)(ii) of the Act Qualifying APM Participants (QPs) are not MIPS eligible clinicians and are excluded from MIPS payment adjustments. Partial Qualifying APM Participants (Partial QPs) are also not MIPS eligible clinicians unless they opt to report and be scored under MIPS. All other eligible clinicians participating in Alternative Payment Models (APMs), including those participating in MIPS APMs, are MIPS eligible clinicians and subject to MIPS requirements, including reporting requirements and payment adjustments (unless otherwise excluded. However, CMS previously finalized the APM Scoring Standard “designed to reduce

reporting burden for participants in certain APMs by minimizing the need for them to make duplicative data submissions for both MIPS and their respective APMs.” (p. 234).

CMS reiterated its previously finalized criteria to be considered a MIPS APM:

- (1) APM Entities participate in the APM under an agreement with CMS or by law or regulation;
- (2) The APM requires that APM Entities include at least one MIPS eligible clinician on a Participation List;
- (3) The APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on cost/utilization and quality measures (p. 235).

In putting forth the CY 2018 proposals, CMS stated that under the APM Scoring Standard:

- **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.**
- Under Cost, IA, and ACI performance categories: The generally applicable MIPS policies are applicable *unless* a separate policy has been established or is being proposed under the APM Scoring Standard.
- Under the Quality performance category: CMS proposes a separate, unique standard under the APM Scoring Standard and generally applicable MIPS policies are *not* applied (unless specifically stated).
- **CMS seeks comment on whether there are potential conflicts or inconsistencies 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.”** (p. 236).

Assessment Dates for Inclusion of MIPS Eligible Clinicians in APM Entity Groups Under the APM Scoring Standard (p. 237)

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. Those eligible clinicians will be scored under the APM Scoring Standard; conversely, MIPS eligible clinicians not on a Participation List on one of those assessment dates are not scored under the APM Scoring Standard and would submit data under another MIPS data submission mechanism to be assessed as an individual or group. In addition to the previously finalized assessment dates of March 31, June 31, 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.”** (p. 237).⁴ The addition of the fourth assessment date only applies in the case of a “Full TIN APM” and only for purposes of apply the APM Scoring Standard. That is, **CMS does not propose to utilize the fourth assessment date of December 31 for purposes of making QP determinations** (p. 238). CMS declined to apply the proposed fourth assessment to all MIPS APMs out of concern that MIPS eligible clinicians could “inappropriately leverage the fourth assessment date to avoid reporting and scoring under the generally applicable MIPS scoring standard when they were part of the MIPS APM for only a very limited portion of the performance year.”

Calculating MIPS APM Performance Category Scores (p. 239)

In setting the APM Scoring Standard, CMS reiterated that its policies were directed at avoiding misaligned incentives between evaluation occurring under MIPS and separately under APMs (e.g. with quality and cost). CMS also sought to eliminate unnecessary reporting and duplication.

⁴ CMS proposes to define a “Full TIN APM” as “an APM where participation is determined at the TIN level, and all eligible clinicians who have assigned their billing rights to a participating TIN are therefore participating in the APM.” (p. 237). CMS cites the Shared Savings Program as a Full TIN APM as it requires all individuals and entities that have reassigned their right to receive Medicare payment to the TIN of an ACO participating to participate in the ACO.

- **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* (i.e. to set the weight of the Cost Performance Category under the APM Scoring Standard at 0%). While CMS is required to incorporate performance improvement into 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* ([p. 241](#)).
- **Quality Performance Category.**
 - *Shared Savings Program and Next Generation ACO Models.* 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.* In addition to the data already used from CMS Web Interface submissions, *CMS proposes to score the CAHPS for ACOs survey under the Quality Performance Category for the APM Scoring Standard beginning in the 2018 performance year for participants in the Shared Savings Program and Next Generation ACO Model* ([p. 242](#)).⁵
 - *Calculation of Quality Scores.* While CMS states that finalized and proposed changes related to calculation of Quality Performance Category scores for MIPS Eligible Clinicians generally apply to APM Entity groups, *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* ([p. 245](#)).
 - *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* ([p. 245](#)). 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.
 - *Scoring Quality Improvement.* *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* ([p. 246](#)). For more information, see the discussions “[Scoring Improvement for the MIPS Quality Performance Category Percent Score](#)” and “[Calculating the Quality Performance Category Percent Score Including Improvement.](#)”

⁵ CMS noted that the CAHPS for ACO survey is well-aligned with CAHPS for MIPS in that it all CAHPS for ACO survey questions are included in the CAHPS for MIPS survey with the exception of the “Between Visit Communication” question which was never scored under and which CMS continues to believe is inappropriate for ACOs ([p. 243](#)).

- Other MIPS APMs. Under the APM Scoring Standard, **CMS proposes to define “Other MIPS APMs” as all MIPS APMs that do not require reporting through the CMS Web Interface (p. 246)**.
 - Quality Performance Category. 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. **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 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 (p. 249)**. CMS presents the measures proposed for inclusion in the Quality Performance Category under each Other MIPS APM for purposes of the APM Scoring Standard in the following tables:
 - **Table 14:** Oncology Care Model
 - **Table 15:** Comprehensive ESRD Care
 - **Table 16:** Comprehensive Primary Care Plus (CPC+)

Scoreable Other MIPS APM Measures. In order for Other MIPS APMs quality measures to be scored, **CMS proposes that it will only score measures that meet the following four criteria:**

- (1) Measures that are tied to payment as described under the terms of the APM (p. 250)
- (2) Measures that are available for scoring near the close of the MIPS submission period (p. 251)
- (3) Measures that have a minimum of 20 cases available for reporting (p. 251): If a measure is reported by fails the 20 case minimum, 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) (p. 253). 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 (p. 257).
- (4) Measures that have an available benchmark (p. 252): 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).

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 (p. 252). If an APM Entity misses the MIPS submission deadline the APM Entity would receive a zero for those measures. 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 (p. 253). As is the case under general scoring, bonus points (i.e. for reporting high priority measures or measures with end-to-end CEHRT) will be awarded on measures beyond the minimum number of required measures.

Quality Scoring Methodology. With regard to scoring quality measure performance under the APM Scoring Standard, CMS proposes to use a decile distribution as in the finalized MIPS quality scoring methodology. CMS will use a graduated points-assignment approach. CMS illustrates an example in Table 11. 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 (p. 255).

Because of the nature of the APM reporting requirements on their own combined with the proposed APM Scoring Standard methodology, CMS does not believe it is necessary to set a point-floor nor a cap on topped out measures for MIPS APMs (p. 256). However, 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 (p. 256). Likewise, 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 (p. 256). CMS will identify whether each Other MIPS APM measure that is used under the Quality Performance Category for the APM Scoring Standard is eligible for bonus points.

The formula for calculating an APM Entity's Quality Performance Category score percentage:

$$\frac{[\text{Achievement Points} + \text{Applicable Bonus Points}]}{\text{Total \# of Available Achievement Points}}$$

This will have a cap of 100% (p. 256).

Quality Improvement Scoring. CMS proposes to begin scoring "improvement" in addition to "achievement" in the Quality Performance Category, including under the APM Scoring Standard (p. 257). The APM Scoring Standard improvement scoring methodology is as follows:

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

10

CMS refers readers to the general MIPS quality performance category improvement scoring methodology at [“Scoring Improvement for the MIPS Quality Performance Category Percent Score.”](#)

Total Quality Performance Category Score. CMS proposes that the methodology for calculating the total score is as follows ([p. 258](#)):

$$\begin{aligned} & [\text{Achievement Points} + \text{Bonus points} / \text{Total Available Achievement Points}] \\ & \qquad \qquad \qquad + \\ & \qquad \qquad \qquad \text{Quality Improvement Score} \end{aligned}$$

- **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. Under statute, APM Entities will at least receive one half of the total possible points. If the MIPS APM Improvement Activities assigned score does not represent the maximum Improvement Activities score, the APM Entity will be able to report additional improvement activities to add points to the APM Entity level score ([p. 258](#)).
- **Advancing Care Information (ACI) Performance Category.** For 2017, 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 then uses those scores to create an APM Entity’s score based on the average of the highest scores available for the MIPS eligible clinicians in the APM Entity group ([p. 258](#)). CMS states that if an individual or TIN did not report on the ACI Performance Category, they will contribute a zero to the APM Entity’s aggregate score. Each MIPS eligible clinician in an APM Entity group will receive one score weighted equally with the scores of every other MIPS eligible clinician in the APM Entity group. CMS then calculates a single APM Entity-level ACI Performance Category score ([p. 259](#)).

Special Circumstances. CMS 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 ([p. 259](#)):

- **ASC-based MIPS eligible clinicians; and**
- **MIPS eligible clinicians who are using decertified EHR technology.**

CMS refers readers to the proposals for these additions in the [ACI section of the rule](#).

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.**

Under this methodology, therefore, all MIPS eligible clinicians in the TIN count toward the TIN’s weight when calculating an aggregated APM entity score for the ACI Performance Category ([p. 259](#)).

If the qualifying MIPS eligible clinician is a solo practitioner or all MIPS eligible clinicians in a TIN qualify for 0% weighting, the TIN is not required to report on the ACI Performance Category, and if it chooses to not, that TIN is assigned a weight of 0 when calculating the APM Entity's ACI Performance Category score. If all individuals or TINs in an APM Entity qualify for 0% weighting, the APM Entity ACI Performance Category would be weighted at 0% in the final score and the weight is redistributed to the quality performance category ([p. 260](#)).

Calculating Total APM Entity Score ([p. 260](#))

For the 2018 Performance Period, **CMS proposes the following APM Scoring Standard category weights for all APM Entities in Other MIPS APMs** (which will align with the previously finalized weights for APMs reporting quality data via the Web Interface:

APM Scoring Standard Weights	
Cost	0%
Quality	50%
Improvement Activities	20%
ACI	30%

In addition,

- 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%

The performance category scoring and total APM entity scoring proposals are summarized in [Table 12](#). Policies related to category reweighting when a performance category results in a 0% weight are summarized in [Table 13](#).

Additional Provisions Addressed in General MIPS Scoring Standard

- **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](#)" ([p. 264](#)).
- **APM Scoring Standard Small Practice Bonus.** CMS directs readers to the small practice adjustment section of the MIPS Scoring Methodology described under "[Small Practice Bonus](#)" ([p. 264](#)).
- **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 ([p. 264](#)).

MIPS APM Performance Feedback ([p. 265](#))

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"** ([p. 265](#)). In addition, **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.**⁶ In effect, this means that CMS will not provide MIPS APMs with feedback on the Cost Performance

⁶ CMS states: "We believe that with an APM Entity's finite resources for engaging in efforts to improve quality and lower costs for a

Category.

MIPS Final Score Methodology (p. 284)

CMS identifies the following proposals as continuing the transition to MIPS:

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

Additional details on these policies are provided below. CMS also specifies that, for the purposes of scoring policies:

- The term "MIPS eligible clinician" will refer to MIPS eligible clinicians that submit data and are scored at either the individual- or group-level, including virtual groups, but will not refer to MIPS eligible clinicians who elect facility-based scoring.
- The APM scoring standard applies to APM Entities in MIPS APMs, and those policies take precedence where applicable; however, where those policies do not apply, general scoring rules will apply.

MACRA specifies that, beginning with the 2020 MIPS payment year, if data sufficient to measure improvement are available, the final score methodology shall take into account improvement of the MIPS eligible clinician in calculating the performance score for the quality and cost performance categories and may take into account improvement for the improvement activities and advancing care information performance categories. In addition, section 1848(q)(3)(B) of the Act provides that the Secretary, in establishing performance standards for measures and activities for the MIPS performance categories, shall consider: historical performance standards; improvement; and the opportunity for continued improvement. Section 1848(q)(5)(D)(ii) of the Act also provides that achievement may be weighted higher than improvement.

CMS details its deliberations when considering an improvement methodology, including consideration of how improvement is incorporated into other Medicare programs, starting on [page 286](#). In its considerations, CMS noted that the wide variety of measures available under the quality performance category and the flexibility clinicians have in selecting different measures and submission mechanisms could affect its ability to capture performance changes at the measure level. This is in contrast to the cost performance category, where MIPS eligible clinicians do not have a choice in measures. Based on these deliberations, CMS proposes the following:

- ***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.*** CMS notes that this is particularly important as CMS encourages MIPS eligible clinicians to move away from topped out measures and toward more outcome measures.
- ***For the cost performance category, CMS proposes to measure improvement at the measure level.*** However, because CMS is also proposing to weight the cost performance category at 0% for the 2018 MIPS performance period/2020 MIPS payment year, the improvement score for the cost performance category would not affect the MIPS final score and would be for informational purposes only.

specified beneficiary population, the incentives of the APM must take priority over those offered by MIPS in order to ensure that the goals and evaluation associated with the APM are as clear and free of confounding factors as possible." [\(p. 265\)](#).

- **CMS does not propose to score improvement in the improvement activities performance category or the ACI performance category at this time**, though CMS may address improvement scoring for these categories in future rulemaking.

Additional detail on measuring improvement is found under [“Scoring Improvement for the MIPS Quality Performance Category Percent Score”](#) and [“Measuring Improvement for the Cost Performance Category”](#), respectively, below. **CMS invites public comment on its proposals to score improvement for the quality and cost performance categories starting with the 2020 MIPS payment year.**

Scoring Flexibility for ICD-10 Measure Specification Changes During the Performance Period (p. 292)

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 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 on 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.** Depending on the data available, CMS anticipates that a determination as to whether a measure is significantly impacted by ICD-10 coding changes would include these factors: a more than 10% change in codes in the measure numerator, denominator, exclusions, and exceptions; guideline changes or new products or procedures reflected in ICD-10 code changes; and feedback on a measure received from measure developers and stewards. **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.**

CMS requests comment on this proposal. CMS also requests comment on potential alternate approaches to address measures that are significantly impacted due to ICD-10 changes during the performance period, including the factors CMS might use to determine whether a measure is significantly impacted.

Scoring the Quality Performance Category for Data Submission via Claims, Data Submission via EHR, Third Party Data Submission Options, CMS Web Interface, and Administrative Claims (p. 294)

In response to comments requesting additional clarification on the final scoring methodology for the 2019 MIPS payment year, CMS provides a summary of finalized scoring policies starting on [page 294](#), along with examples. **CMS notes that, for the quality category, CMS is using updated terminology and proposes to update regulation text related to Quality category scoring as follows:**

- Replace “achievement points” with “measure achievement points”
- Replace “bonus points” with “measure bonus points”
- Replace “total possible points” with “total available measure achievement points”
- Replace “quality performance category score” with “quality performance category percent score”

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 also proposes modifications to scoring the quality performance category, as detailed below.

Quality Measure Benchmarks (p. 299)

CMS notes that, because of the proposed increase to the low-volume threshold included in this year's rule, MIPS benchmarks could be affected as fewer individual eligible clinicians and groups would meet the definition of a MIPS eligible clinician to contribute to benchmarks. **Therefore, 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 also notes that they did not stratify benchmarks by practice characteristics, such as practice size, because they did not believe there was a compelling rationale for such an approach and that they believed that stratifying could have unintended negative consequences for the stability of benchmarks, equity across practices, and quality of care for beneficiaries. Starting on [page 301](#), CMS summarizes comments received in response to a solicitation on rationales for or against stratifying by practice size, and notes that, after consideration of comments received, **CMS does not propose any change to policies related to stratifying benchmarks by practice size for the 2020 MIPS payment year.** While CMS continues to have concerns about potential negative consequences, **CMS 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 multi-specialty practices or by practices that operate in multiple places of service.**

Assigning Points Based on Achievement (p. 302)

In general, CMS does not propose changes to its previously finalized benchmarking methodology for the quality performance category, including using a percentile distribution, separating by decile categories, and assigning partial points based on the percentile distribution.

Similar to the policy for the 2017 MIPS performance period, **CMS proposes to again apply a 3-point floor for each measure that can be reliably scored against a benchmark based on the baseline period, 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 invites public comment on this proposal.**

CMS previously finalized a policy for the CAHPS for MIPS measure, under which each Summary Survey Measure (SSM) will have an individual benchmark, CMS will score each SSM individually against the benchmark, and the CAHPS score will be the average number of points across SSMs. Since CMS [proposes to remove two SSMs from the CAHPS for MIPS survey](#), 10 SSMs would remain. Eight of those 10 SSMs have had high reliability for scoring in prior years, or reliability is expected to improve for the revised version of the measure, and they also represent elements of patient experience for which CMS can measure the effect one practice has compared to other practices participating in MIPS. For reasons discussed starting on [p. 305](#), **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 invites comment on the proposal not to score the "Health Status and Functional Status" and "Access to Specialists" SSMs beginning with the 2018 MIPS performance period.**

Identifying and Assigning Measure Achievement Points for Topped Out Measures (p. 306)

In the CY 2017 QPP final rule, CMS finalized that topped out measures would be scored in the same manner as other measures for the 2019 MIPS payment year and for the first year that a measure has been identified as topped out, but that CMS would modify the benchmark methodology for topped out measures beginning with the 2020 MIPS payment year. CMS also solicited comment on how topped out measures should be scored, and provided summaries of comments received.

[As noted above](#), CMS proposes a lifecycle for topped out measures by which, after a measure benchmark is

identified as topped out in the published benchmark for 2 years, in the third consecutive year it is identified as topped out it will be considered for removal through notice-and-comment rulemaking or the QCDR approval process, and may be removed from the benchmark list in the fourth year. CMS does not propose to remove any topped out measures for the 2018 MIPS performance period. CMS also notes that, because benchmarks are created separately for each submission mechanism, a measure may be identified as topped out for one mechanism but not another, and topped out designation and special scoring only apply to the specific benchmark/submission mechanism.

As part of the proposed measure lifecycle, CMS proposes a method to phase in special scoring for topped out measure benchmarks starting with the 2018 MIPS performance period, provided 2018 is the second consecutive year the measure benchmark is identified as topped out in the published benchmarks. ***Specifically, 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.*** These policies apply to scoring achievement and would not affect CMS' policy for awarding measure bonus points for topped out measures. ***CMS request comments on the proposal to score topped out measures differently by applying a 6-point cap, provided it is the second consecutive year the measure is identified as topped out. Specifically, CMS seeks feedback on whether 6 points is the appropriate cap or whether CMS should consider another value. CMS also seeks comment on other possible options for scoring topped out measures that would meet policy goals to encourage clinicians to begin to submit measures that are not topped out while also providing stability for MIPS eligible clinicians.***

Given that numerous measure benchmarks are currently identified as topped out and special scoring for topped out measures could impact some specialties more than others, CMS considered ways to phase in special scoring for topped out measures. ***To accomplish this, CMS proposes applying the special topped out scoring to only 6 measures (see [Table 21](#)) for the 2018 performance period*** before applying it to all applicable topped out measures for the 2019 performance period, based on the application of several criteria (see discussion of criteria on [p. 312](#)), assuming these measures are again identified as topped out for that 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. CMS seeks comment on its proposal to apply special topped out scoring to all topped out measures, provided it is the second (or more) consecutive year the measure is identified as topped out. CMS specifically seeks comment on whether the proposed policy to cap the score of topped out measures beginning with the 2019 performance period should apply to SSMs in the CAHPS for MIPS survey measure or whether there is another alternative policy that could be applied for the CAHPS for MIPS survey measure due to high, unvarying performance within the SSM. CMS notes that it would like to encourage groups to report the CAHPS for MIPS survey as it incorporates beneficiary feedback.

CMS does not propose to apply a special scoring adjustment to topped out measures for CMS Web Interface for the QPP.⁷ Additionally, because the Shared Savings Program incorporates a methodology for measures with high performance into the benchmark, CMS does not propose to apply the topped out measure cap to measures in the CMS Web Interface for the QPP. ***CMS seeks comment on this proposal not to apply the topped out measure cap to measures in the CMS Web Interface for the QPP.***

Case Minimum Requirements and Measure Reliability and Validity ([p. 318](#))

CMS does not propose any changes to its case minimum policies that require at least 20 cases for all quality measures except the all-cause hospital readmission measure, which requires at least 200 cases and only applies to groups of 16 or more clinicians that meet the case minimum requirement.

⁷ Note that this statement is pulled from page 317. Based on surrounding language, we interpret this proposal to mean that CMS will not apply the lifecycle for topped out measures, such that CMS would not remove topped out measures from the CMS Web Interface.

For the 2019 MIPS payment year, CMS finalized two classes of measures:

- Class 1 measures that can be scored based on performance because they have a benchmark, meet the case minimum requirement, and meet the data completeness standard. These measures can receive scores of 3 to 10 based on performance compared to the benchmark.
- Class 2 measures that cannot be scored based on performance because they do not have a benchmark, do not have at least 20 cases, or have not met data completeness criteria. These measures receive 3 points for the 2019 MIPS payment year.

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.

These policies for Class 2 and Class 3 measures would not apply to measures submitted with the CMS Web Interface or administrative claims-based measures. However, ***CMS proposes to add that CMS Web Interface measures with a benchmark that are re-designated from pay for performance to pay for reporting by the Shared Savings Program will not be scored.*** CMS is also not proposing any changes to the policy to not include administrative claims measures in the quality performance category percent score if the case minimum is not met or if the measure does not have a benchmark.

A summary of the proposals is provided in [Table 23](#). ***CMS invites comment on these proposals.***

Scoring for MIPS Eligible Clinicians that Do Not Meet Quality Performance Category Criteria (p. 322)

CMS does not propose any changes to the previously finalized policy to assign 0 points for failing to submit a measure that is required in this proposed rule. Likewise, CMS does not propose any changes to the policy to apply a process to validate whether MIPS eligible clinicians that submit measures via claims and registry submissions have measures available and applicable, or to the policy to not establish a validation process for QCDRs as CMS expects clinicians enrolled in QCDRs will have sufficient meaningful measures to meet the quality performance category. CMS also stated in the 2017 QPP final rule that if a MIPS eligible clinician did not have 6 measures relevant within their EHR to meet the full specialty set requirements or meet the requirement to submit 6 measures, the MIPS eligible clinician should select a different submission mechanism to meet the quality performance category requirements and should work with their EHR vendors to incorporate applicable measures as feasible.

Given these previously finalized policies and CMS' proposal to score multiple mechanisms for submitted measures, ***CMS proposes 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. 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.*** CMS will not check if there are measures available via EHR or QCDR submission options for these reporters. Additionally, because groups cannot report via claims, groups and virtual groups will only have validation applied across registries. For CMS to recognize fewer than 6 measures, an individual MIPS eligible clinician must submit exclusively using claims or

qualified registries or a combination of the two, and a group or virtual group must submit exclusively using qualified registries. Validation will be conducted first by applying the clinically related measure analysis for the individual measure and then, to the extent technically feasible, validation will be applied to check for available measures available via both claims and registries.

CMS acknowledges that in extremely rare instances there may be a MIPS eligible clinician who may not have available and applicable quality measures. If CMS is not able to score the quality performance category, CMS may reweight the score according to the reweighting policies described under [“Flexibility for Weighting Performance Categories.”](#)

Incentives to Report High Priority Measures (p. 325)

CMS does not propose any changes regarding incentives to report high priority measures, such that the following policies remain in effect for measures reported in addition the 1 high priority measure required, as long as the measure has a performance rate greater than 0 and meets the case minimum and data completeness requirements:

- CMS awards 2 bonus points for each outcome or patient experience measure
- CMS awards 1 bonus point for each additional high priority measure
- CMS applies measure bonus points for the CMS Web Interface for the QPP based on the finalized set of measures, as well as bonus points for submitting the CAHPS for MIPS survey
- CMS applies a cap on high priority measure bonus points at 10% of the denominator of the quality performance category (also applicable to the CMS Web Interface for the QPP) for the first 2 years of MIPS.

Incentives to Use CEHRT to Support Quality Performance Category Submissions (p. 326)

CMS does not propose any changes regarding incentives to use CEHRT under the quality performance category, such that the following policies remain in effect:

- CMS awards 1 bonus point for each quality measure submitted with end-to-end electronic reporting
- CMS applies a cap on the number of bonus points available for electronic end-to-end reporting at 10% of the denominator of the quality performance category percent score, for the first 2 years of the program
- CEHRT bonus points are available to all submission mechanisms except claims submissions.

However, ***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 welcomes public comment on these questions.***

Calculating Total Measure Achievement and Measure Bonus Points (p. 327)

Calculating Total Measure Achievement and Measure Bonus Points for Non-CMS Web Interface Reporters (p. 327). In the CY 2017 QPP final rule, CMS finalized that if a MIPS eligible clinician elects to report more than the minimum number of measures to meet the MIPS quality performance category criteria, then CMS will only include the scores for the measures with the highest number of assigned points, once the first outcome measure (or other high priority measure) is scored. CMS does not propose any changes to this policy; however, CMS proposes refinements to account for measures being submitted across multiple submission mechanisms.

Specifically, 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 will separately continue to score

the CMS-approved survey vendor for CAHPS for MIPS submission option in conjunction with other submission mechanisms. [Table 24](#) summarizes how scoring is allowed across multiple mechanisms.

CMS proposes to score measures across multiple mechanisms using the following rules:

- ***CMS will only score measures within a single identifier.*** That is, measures can only be scored across multiple mechanisms if reported by the same individual MIPS eligible clinician, group, virtual group or APM Entity. ***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).*** Virtual groups are treated like other groups and must report all of their measures at the virtual group level, for the measures to be scored. Data completeness and all the other criteria will be evaluated at the virtual group level. If a virtual group representative submits some measures via a qualified registry and other measures via EHR, but an individual TIN within the virtual group also submits measures, CMS will only use the scores from the measures that were submitted at the virtual group level, because the TIN submission does not use the virtual group identifier. This is consistent with other scoring principles, where, for virtual groups, all quality measures are scored at the virtual group level.
- Separately, because CMS Web Interface and facility-based measurement each have a comprehensive set of measures that meet the proposed MIPS submission requirements, ***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*** (as noted by the measure number) that meets the criteria for earning the bonus point. If the same measure is submitted through multiple submission mechanisms, CMS would apply the bonus points only once to the 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.***

Although CMS provides a policy to account for scoring in those circumstances when the same measure is submitted via multiple mechanisms, CMS anticipates that this will be a rare circumstance and does not encourage clinicians to submit the same measure via multiple mechanisms. [Table 25](#) illustrates how CMS would assign total measure achievement points and total measure bonus points across multiple submission mechanisms under the proposal.

CMS invites comments on these proposals. CMS does not propose any changes to the policy that if a MIPS eligible clinician does not have any scored measures, then a quality performance category percent score will not be calculated. CMS anticipates that it will be only in rare case that a MIPS eligible clinician does not have any scored measures and a quality performance category percent score cannot be calculated.

Calculating Total Measure Achievement and Measure Bonus Points for CMS Web Interface Reporters (p. 335).

In the CY 2017 QPP final rule, CMS finalized that CMS Web Interface reporters are required to report 14 measures, but since 3 measures did not have a benchmark in the Shared Savings Program in the transition year, CMS Web Interface reporters are scored on 11 of the total 14 required measure. CMS also finalized a global floor of 3 points for all CMS Web Interface measures submitted in the transition year, even with measures at 0% performance rate, provided that these measures have met the data completeness criteria, have a benchmark and meet the case minimum requirements. CMS stated that it would reassess scoring for measures below the 30th percentile in future years.

For the 2018 MIPS performance year, ***CMS proposes to continue to assign 3 points for measures with performance below the 30th percentile, provided the measure meets data completeness, has a benchmark, and meets the case minimum requirements***; CMS makes this proposal in order to continue to align with the 3-point floor for other measures and because the Shared Savings Program does not publish benchmarks with values below the 30th percentile. CMS will reassess this policy again next year through rulemaking.

CMS does not propose any changes to the 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. ***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 invites comment on this proposal.***

CMS clarifies that groups that submit measures via the CMS Web Interface may also submit and be scored on CMS-approved survey vendor for CAHPS for MIPS submission options. In addition, groups of 16 or more eligible clinicians that meet the case minimum for administrative claims measures will automatically be scored on the all-cause hospital readmission measure and have that measure score included in their quality performance percent score. CMS does not propose any changes to calculating the total measure achievement points and measure bonus points for CMS Web Interface measures in this proposed rule, although CMS proposes to add improvement to the quality performance category percent score.

Scoring Improvement for the MIPS Quality Performance Category Percent Score (p. 337)

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.

To qualify for an improvement percent score, CMS proposes the following requirements.

- ***Data sufficiency.*** With respect to data sufficiency, ***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 notes that, by measuring improvement based only on the overall quality performance category achievement percent score, some MIPS eligible clinicians may generate an improvement score simply by switching to measures on which they perform more highly, rather than actually improving at the same measures. CMS will monitor how frequently improvement is due to actual improvement versus switching measures and will address through future rulemaking, as needed. ***CMS also solicits comment on whether to require some level of year to year consistency when scoring improvement.***

- **CMS proposes that “comparability” of quality performance category achievement percent scores would be established by looking first at the submitter 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.**

There are instances where CMS would not be able to measure improvement due to lack of sufficient data, for example, if the MIPS eligible clinicians were not eligible to participate in MIPS in the previous year. [Table 26](#) summarizes the different cases when a group or individual would be eligible for improvement scoring under this proposal. **CMS invites public comments on the proposals as they relate to data sufficiency for improvement scoring.**

CMS also seeks comment on an alternative to this proposal: whether CMS should restrict improvement to those who submit quality performance data using the same identifier for two consecutive MIPS performance periods. CMS believes this option would be simpler to apply, communicate and understand than the proposal is, but this alternative could have the unintended consequence of not allowing improvement scoring for certain MIPS eligible clinicians, groups, virtual groups and APM entities.

- **Full participation. CMS is also proposing that MIPS eligible clinicians must fully participate in the current performance year to receive an improvement score.** Full participation entails the submission of all required measures, including meeting data completeness, for the quality performance category for the current performance period. **CMS 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. CMS invites public comment on this proposal.**

To calculate improvement percent score, CMS proposes the following:

- **Prior year floor.** Given the 3-point floor for any scored measure that would have led to an achievement score of at least 30% for individuals who fully participated in the transition year, **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 believes this approach appropriately recognizes the participation of MIPS eligible clinicians who participated in the transition year and accounts for MIPS eligible clinicians who participated minimally and may otherwise be awarded for an increase in participation rather than an increase in achievement performance. **CMS invites public comment on this proposal.**

- **Focus on achievement performance. CMS proposes to focus on improvement based on achievement performance and would not consider measure bonus points in our 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. CMS invites public comment on this proposal to award improvement based on changes in the quality performance category achievement percent score.**
- **Calculation of “Improvement Percent Score.”** To calculate an improvement percent score, **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 explains that this would mean a 20% rate of improvement for achievement (for example) would be worth a 2 percentage point increase to the quality performance category achievement percent score. **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.** [Table 28](#) provides examples of the proposed improvement percent scoring methodology, which is based on rate of increase in quality performance category achievement percent scores.

CMS also considered two alternatives for measuring improvement:

- CMS considered an alternative to measuring the rate of improvement, which would use band levels to determine the improvement points ([p. 352](#)). Under this alternative, a MIPS eligible clinician’s improvement points would be determined by an improvement in the quality performance category achievement percent score from one year to the next year to determine improvement in the same manner as set forth in the rate of improvement methodology. However, for the band level methodology, an improvement percent score would then be assigned by taking into account a portion (50, 75 or 100%) of the improvement in achievement, based on the clinician’s performance category achievement percent score for the prior year. Bands would be set for category achievement percent scores, with increases from lower category achievement scores earning a larger portion (percentage) of the improvement points. Under this alternative, simple improvement percentage points for improvement are awarded to MIPS eligible clinicians whose category scores improved across years according to the band level, up to a maximum of 10% of the total score. In [Table 29](#), CMS illustrate the band levels CMS considered as part of this alternative proposal. [Table 30](#) illustrates examples of the improvement scoring methodology based on band levels. Generally, this methodology would generate a higher improvement percent score for clinicians; however, CMS believes the policy CMS proposed would provide a score that better represents true improvement at the performance category level, rather than comparing simple increases in performance category scores.
- CMS considered another alternative that would adopt the improvement scoring methodology of the Shared Savings Program for CMS Web Interface submissions in the quality performance category ([p. 354](#)). Under the Shared Savings Program approach, eligible clinicians and groups that submit through

the CMS Web Interface would have been required to submit on the same set of quality measures, and CMS would have awarded improvement for all eligible clinicians or groups who submitted complete data in the prior year. As Shared Savings Program and Next Generation ACOs report using the CMS Web Interface, using the same improvement score approach would align MIPS with these other programs. CMS believed it could be beneficial to align improvement between the programs because it would align incentives for those who participate in the Shared Savings Program or ACOs. The Shared Savings Program approach would test each measure for statistically significant improvement or statistically significant decline. CMS would sum the number of measures with a statistically significant improvement and subtract the number of measures with a statistically significant decline to determine the Net Improvement. CMS would next divide the Net Improvement in each domain by the number of eligible measures in the domain to calculate the Improvement Score.

CMS invites public comments on the proposal to calculate improvement scoring using a methodology that awards improvement points based on the rate of improvement and, alternatively, on rewarding improvement at the band level or using the Shared Saving Program approach for CMS Web Interface submissions.

Calculating the Quality Performance Category Percent Score Including Improvement (p. 356)

CMS previously finalized that the quality performance category score is the sum of all points assigned for the measures required for the quality performance category criteria plus bonus points, divided by the sum of total possible points. This formula was represented as: *Quality performance category percent score = (total measure achievement points + measure bonus points)/total available measure achievement points.*

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. Table 31 illustrates an example of calculating the quality performance category percent score including improvement for a non-CMS Web Interface reporter. CMS notes that the quality performance category percent score is then multiplied by the performance category weight for calculating the final score. CMS invites public comment on this overall methodology and formula for calculating the quality performance category percent score.

Scoring the Cost Performance Category (p. 359)

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 does not propose any changes to the methodology for scoring achievement in the cost performance category for the 2020 MIPS payment year other than as described under [“Facility-Based Measures Scoring Option for the 2020 MIPS Payment Year.”](#)

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.

Measuring Improvement for the Cost Performance Category (p. 360)

Calculating Improvement at the Cost Measure Level (p. 360). For the cost performance category, ***CMS proposes that improvement scoring is available to MIPS eligible clinicians and groups that demonstrate improvement in performance in the current MIPS performance period compared to their performance in the immediately preceding MIPS performance period, and that improvement will be measured at the measure level.*** CMS believes that CMS would have data sufficient to measure improvement when CMS can measure performance in the current performance period compared to the prior performance period.

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 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 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.

For MIPS payment year 2020, the total available cost improvement score would be limited to the 2 cost measures that would be available in both the first and second performance periods of the program (total per capita cost and Medicare Spending Per Beneficiary). MIPS eligible clinicians would be able to review their performance feedback and make improvements compared to the score in their previous feedback. ***CMS invites public comments on these proposals.***

Improvement Scoring Methodology (p. 363). 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. However, as an alternative, CMS welcomes public comments on whether CMS should consider instead adopting an improvement scoring methodology that measures improvement in the cost performance category the same way CMS proposes to do in the quality performance category; that is, using the rate of improvement and without requiring statistical significance.

Since MIPS is still in its beginning years, and because CMS has proposed the cost performance category to be weighted at 0%, CMS believes that the focus of clinicians should be on achievement as opposed to improvement. ***Therefore, 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;*** thus, the cost improvement score would not contribute to the cost performance category percent score calculated for the 2020 MIPS payment year. ***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 invites comments on these proposals as well as alternative ways to measure changes in statistical significance for the cost measure.

Calculating the Cost Performance Category Percent Score with Achievement and Improvement (p. 367)
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).

Facility-Based Measures Scoring Option for the 2020 MIPS Payment Year for the Quality and Cost Performance Categories (p. 369)

Section 1848(q)(2)(C)(ii) of the Act provides that the Secretary may use measures used for payment systems other than for physicians, such as measures for inpatient hospitals, for purposes of the quality and cost performance categories. However, the Secretary may not use measures for hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists. CMS considered, but did not propose, an option for facility-based measures scoring in the transition year. ***For the 2020 MIPS payment year and onward, CMS proposes to implement facility-based measures to add more flexibility for clinicians to be assessed in the context of the facilities at which they work.*** CMS believes that it is appropriate to implement this scoring option in a limited fashion in the first year by focusing on inpatient hospital measures in certain pay-for-performance (versus pay-for-reporting) program.

In general, 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.

Measures in the FY 2019 Hospital VBP Program are identified in [Table 33](#). CMS includes rationale for this decision to focus on Hospital VBP starting on [p. 371](#). CMS also provides a rationale, proposals, and requests for comment regarding the selection of the FY 2019 Hospital VBP program year, for which quality measurement will be concluded by December 31, 2017, and for which Hospital VBP Program scoring reports must be provided to participating hospitals not later than 60 days prior to the beginning of FY 2019:

- CMS believes that MIPS eligible clinicians electing the facility-based measurement option under MIPS should be able to consider as much information as possible when making that decision. ***Therefore, 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 seeks to provide Hospital VBP scores to clinicians by the time the data submission period for the 2018 MIPS performance period begins assuming that timeframe is operationally feasible. However, CMS notes that this policy could conceivably place non-facility-based MIPS eligible clinicians at a competitive disadvantage since they would not have any means by which to ascertain their MIPS measure scores in advance. ***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.*** Notification after the MIPS performance period would prevent facility-based clinicians from being able to compare their expected MIPS performance category scores under the facility-based measurement option with their expected scores under the options available to all MIPS eligible.

CMS also notes that Hospital VBP Program measures have different measurement periods (some up to 36 months, as shown in [Table 33](#)). ***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.*** CMS also considered whether CMS should include the entire set of Hospital VBP Program measures for purposes of facility-based measurement under MIPS or attempt to differentiate those which may be more influenced by clinicians' contribution to quality performance than others. However, CMS believes that clinicians have a broad and important role as part of the healthcare team at a hospital and that attempting to differentiate certain measures undermines the team-based approach of facility-based measurement.

CMS request comments on these proposals. CMS also request comments on what other programs, if any, CMS should consider including for purposes of facility-based measurement under MIPS in future program years.

Facility-Based Measurement Applicability (p. 376)

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 does not use the hospital-based MIPS eligible clinician definition used under the ACI category since this definition could include many clinicians that have limited or no presence in the inpatient hospital settings, but notes that a clinician determined to be facility-based would likely also be determined to be hospital-based for the purposes of the ACI performance category. CMS does not propose to include POS code 22 in determining whether a clinician is facility-based because many clinicians who bill for services using this POS code may work on a hospital campus but in a capacity that has little to do with the inpatient care in the hospital. **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.** CMS also considered, but does not propose, to further limit facility-based measurement on characteristics (e.g. hospital medicine specialty or patient-facing clinicians).

Clinicians would be determined to be facility-based through an evaluation of covered professional services between September 1 of the calendar year 2 years preceding the performance period through August 31 of the calendar year preceding the performance period with a 30-day claims run out. For example, for the 2020 MIPS payment year, where CMS has adopted a performance period of CY 2018 for the quality and cost performance categories, CMS would use the data available at the end of October 2017 to determine whether a MIPS eligible clinician is considered facility-based by the definition. At that time, those data would include Medicare claims with dates of service between September 1, 2016 and August 31, 2017. In the event that it is not operationally feasible to use claims from this exact time period, CMS would use a 12-month period as close as practicable to September 1 of the calendar year 2 years preceding the performance period and August 31 of the calendar year preceding the performance period. This determination would allow clinicians to be made aware of their eligibility for facility-based measurement near the beginning of the MIPS performance period.

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 (p. 380). 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 also considered an alternative proposal in which a facility-based group would be a group where the TIN overall furnishes 75% or more of its 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 the emergency room, as identified by POS code 23, based on claims for a period prior to the performance period as specified by CMS. Groups would be determined to be facility-based through an evaluation of covered professional services on the same timeline as individuals. **CMS requests comments on this proposal and alternative proposal.**

Facility Attribution for Facility-Based Measurement (p. 381)

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. This mirrors the proposed period of determining if a clinician is eligible for facility-based measurement and also overlaps with parts of the performance period for the applicable Hospital VBP program measures. **For the first year, the value-based purchasing score for the facility is the FY 2019 Hospital VBP Program's Total Performance Score. In cases in which there was an equal number of Medicare beneficiaries treated at more than one facility, CMS proposes to use the value-based purchasing score from the facility with the highest score.**

Election of Facility-Based Measurement (p. 382)

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. If technically feasible, CMS would let the MIPS eligible clinician know that they were eligible for facility-based measurement prior to the submission period, so that MIPS eligible clinicians would be informed if this option is available to them.

CMS also considered an alternative approach of not requiring an election process but instead automatically applying facility-based measurement to MIPS eligible clinicians and groups who are eligible for facility-based measurement, if technically feasible, if the facility-based measurement score is higher than the quality and cost performance category scores based on data submitted. This facility-based measurement score would be calculated even if an individual MIPS eligible clinician or group did not submit any data for the quality performance category. This option would reduce burden for MIPS eligible clinicians by not requiring them to elect facility-based measurement, but is contrary to stakeholders' request for a voluntary policy. Additionally, under this option, considerations about Hospital VBP Program timing would be less applicable. This option may also result in MIPS eligible clinicians being scored on measures at a facility and being unaware that such scoring is taking place, and could provide an advantage to those facility-based clinicians who do not submit quality measures in comparison to those who work in other environments. CMS also notes that this option may not be technically feasible to implement for the 2018 MIPS performance period. ***CMS invites comments on this proposal and alternate proposal.***

Facility-Based Measures (p. 383)

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, noting that measures align with high-priority measures, outcome measures, and the cost performance category. CMS notes that the Patient Safety Composite Measure (PSI-90) was proposed for removal beginning with the FY 2019 measure set in the FY 2018 IPPS/LTCH proposed rule due to issues with calculating the measure score. If the proposal to remove that measure from the hospital measure set is finalized, CMS would remove the measure from the list of those adopted for facility-based measurement in the MIPS program.

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.

Scoring Facility-Based Measurement (p. 386)

CMS provides information on scoring under the Hospital VBP, which includes 13 measures across 4 domains, starting on [p. 386](#) as background information to help understand its proposals for scoring facility-based measures under MIPS. For each of the Hospital VBP measures, CMS calculates an achievement score (which can range from 0 to 10 points and is based on performance relative to the median and top decile of performance) and an improvement score (which can range from 0 to 9 points). For each measure, a hospital is awarded the higher of the achievement or improvement score. In general, points awarded for each measure within each domain are summed to reach the unweighted domain score (special rules apply for the Person and Community Engagement domain). The domain scores are then weighted according to domain weights specified each Program year, then summed to reach the Total Performance Score, which is converted to a value-based incentive payment percentage that is used to adjust payments to each hospital for inpatient services furnished during the applicable program year. For the FY 2019 program year, all 4 domains will be weighted equally.

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 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 proposes to assign category scores as follows:

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

The percentile distribution for both the Hospital VBP Program and MIPS facility-based measurement would be based on the distribution during the applicable performance periods for each of the programs and not on a previous benchmark year.

CMS also includes proposals and comment solicitations on the following aspects of facility-based measurement scoring:

- **Improvement scoring (p. 391). 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.**
 - Regarding the quality performance category, **CMS requests comment on whether it is appropriate to include measurement of improvement in the MIPS quality performance category for facility-based measured clinicians and groups given that the Hospital VBP Program already takes improvement into account in its scoring methodology.** Additionally, because CMS intends to allow clinicians the flexibility to elect facility-based measurement on an annual basis, some clinicians may be measured through facility-based measurement in 1 year and through another MIPS method in the next. Because the first MIPS performance period in which a clinician could switch from facility-based measurement to another MIPS method would be in 2019, **CMS seeks comment on how to assess improvement for those that switch from facility-based scoring to another MIPS method.**
 - For the cost performance category, because CMS proposes to limit measurement of improvement to those MIPS eligible clinicians that participate in MIPS using the same identifier and are scored on the same cost measure(s) in 2 consecutive performance periods, **those MIPS eligible clinicians who elect facility-based measurement would not be eligible for a cost improvement score in the cost performance category under the proposed methodology because they would not be scored on the same cost measure(s) for 2 consecutive performance periods. CMS invites comments on these proposals.**
- **Bonus points (p. 393). Since the proposed facility-based measurement scoring method is based on a percentile distribution of scores that already accounts for bonus points, CMS does not propose to calculate additional high priority bonus points for facility-based measurement.** Additionally, because the Hospital VBP Program does not capture whether or not measures are reported using end-to-end electronic reporting, **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 also provides for special rules for facility-based measurement, as follows:

- [Hospitals that do not receive a Total Performance Score under the Hospital VBP Program \(p. 394\)](#). For hospitals that do not receive a Total Performance Score in a given year whether due to insufficient quality measure data, failure to meet requirements under the Hospital Inpatient Quality Reporting Program, or other reasons, ***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.***
- [Total Performance Score corrections \(p. 395\)](#). Hospitals may submit correction requests to their Total Performance Scores calculated under the Hospital VBP Program, and may also appeal the calculations of their Total Performance Scores. ***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 welcomes public comments on whether a different deadline should be considered.***
- [Scoring floor \(p. 395\)](#). ***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.*** There is no similar floor established for measures in the cost performance category under MIPS, so ***CMS does not propose any floor for the cost performance category for facility-based measurement.***
- [Submission of quality data via another MIPS mechanism \(p. 396\)](#). If a clinician or a group elects facility-based measurement but also submits quality data through another MIPS mechanism, ***CMS proposes to use the higher of the two scores for the quality performance category and base the score of the cost performance category on the same method (that is, if the facility-based quality performance category score is higher, facility-based measurement is used for quality and cost).*** Since this policy may result in a higher final score, it may provide facility-based clinicians with a substantial incentive to elect facility-based measurement, whether or not the clinician believes such measures are the most accurate or useful measures of that clinician's performance. Therefore, this policy may create an unfair advantage for facility-based clinicians over non-facility-based clinicians, since non-facility-based clinicians would not have the opportunity to use the higher of two scores. ***As such, CMS seeks comment on whether this proposal to use the higher score is the best approach to score the performance of facility-based clinicians in comparison to their non-facility-based peers.***

[Scoring the Improvement Activities Performance Category \(p. 397\)](#)

CMS does not propose any changes to the scoring of the improvement activities performance category in this proposed rule relative to policies finalized in the CY 2017 QPP final rule. ***However, CMS proposes the following:***

- To change to how groups qualify for participation in a certified patient-centered medical home or comparable specialty practice, [as described earlier](#).***
- Beginning with the 2018 MIPS performance period, 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. (p. 403) CMS proposes this 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.***

[Scoring the Advancing Care Information \(ACI\) Performance Category \(p. 404\)](#)

CMS refers readers to CMS' discussion of [scoring for the ACI performance category](#).

[Calculating the Final Score \(p. 404\)](#)

[Considerations for Social Risk \(p. 405\)](#)

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. Examples of methods include: adjustment of MIPS eligible clinician scores (for example, stratifying the scores of MIPS eligible clinicians based on the proportion of their patients who are dual eligible); confidential reporting of stratified measure rates to MIPS eligible clinicians; public reporting of stratified measure results; risk adjustment of a particular measure as appropriate based on data and evidence; and redesigning payment incentives (for instance, rewarding improvement for clinicians caring for patients with social risk factors or incentivizing clinicians to achieve health equity). ***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.*** Examples of social risk factors include, but are not limited to the following: dual eligibility/low-income subsidy; race and ethnicity; and geographic area of residence. ***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.***

[Complex Patient Bonus \(p. 407\)](#)

As a short-term strategy for the QPP to address the impact patient complexity may have on final scores, ***CMS proposes a complex patient bonus for the 2018 MIPS performance period (2020 MIPS payment year).*** CMS will assess on an annual basis whether to continue the bonus and how the bonus should be structured. CMS discusses its deliberations on crafting this policy starting on [p. 408](#).

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 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 (p. 418). 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 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.

CMS seeks comments on the proposed bonus for complex patients based on average HCC risk scores, and the alternative option using a ratio of dual eligible patients in lieu of average HCC risk scores. CMS reiterates that the complex patient bonus is intended to be a short-term solution, which CMS plan to revisit on an annual basis, to incentivize clinicians to care for patients with medical complexity. CMS may consider alternate adjustments in future years after methods that more fully account for patient complexity in MIPS have been developed. ***CMS also seeks comments on alternative methods to construct a complex patient bonus.***

Small Practice Bonus for the 2020 MIPS Payment Year (p. 420)

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.
- Group practices, virtual groups, or APM Entities must consist of a total of 15 or fewer clinicians (the entire virtual group or APM entity combined must include 15 or fewer clinicians to qualify for the bonus).

CMS proposes to add this small practice bonus of 5 points to the final score for those clinicians and groups who meet these criteria. CMS believes a bonus of 5 points is appropriate to acknowledge the challenges small practices face in participating in MIPS, and to help them achieve the proposed performance threshold of 15 points. If the result of the calculation is greater than 100 points, then the final score would be capped at 100 points.

CMS invites public comment on the proposal to apply a small practice bonus for the 2020 MIPS payment year. CMS also considered applying a bonus for MIPS eligible clinicians that practice in either a small practice or a rural area. However, on average, CMS saw less than a one point difference between scores for MIPS eligible clinicians who practice in rural areas and those who do not. Therefore, CMS does not propose to extend the final score bonus to those who practice in a rural area, but plan to continue to monitor the QPP’s impacts on the performance of those who practice in rural areas. ***CMS also seeks comment on the application of a rural bonus in the future, including available evidence demonstrating differences in clinician performance based on rural***

status. If CMS implement a bonus for practices located in rural areas, CMS would use the definition for rural specified proposed in this rule for individuals and groups (including virtual groups).

Final Score Calculation (p. 424)

With the proposed addition of the complex patient and small practice bonuses, **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).**

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 performance category weight) + (advancing care information performance category score x 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. This policy is slightly revised from last year (when CMS finalized a policy to assign a MIPS eligible clinician with only 1 scored performance category a final score equal to the performance threshold) to allow for the potential that a MIPS eligible clinician could be scored on zero performance categories given CMS’ proposal under “[Extreme and Uncontrollable Circumstances.](#)”

CMS invites public comment on the proposed final score methodology and associated revisions to regulation text.

Final Score Performance Category Weights (p. 425)

General Weights (p. 425). 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 provided below and included in [Table 37.](#)

TABLE 37: Finalized and Proposed Weights by MIPS Performance Category

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

Flexibility for Weighting Performance Categories (p. 427). Under section 1848(q)(5)(F) of the Act, if there are not sufficient measures and activities applicable and available to each type of MIPS eligible clinician involved, the Secretary is required to assign different scoring weights (including a weight of zero) for each performance category. **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.**

- **For the quality performance category, 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.** If CMS receives no quality performance category submission from a MIPS eligible clinician, the MIPS eligible clinician generally will receive a performance category score of zero (or slightly above zero

if the all-cause hospital readmission measure applies). However, there may be rare instances that could affect only a very limited subset of MIPS eligible clinicians (as well as groups and virtual groups) that may have no quality measures available and applicable. In those instances, CMS would not be able to calculate a quality performance category percent score. CMS would reweight this category in only such a rare cases, or if the MIPS eligible clinician is approved for reweighting this category based on extreme and uncontrollable circumstances.

- **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 measure will not be scored for that clinician.** If CMS does not score any cost measures for a MIPS eligible clinician in accordance with this policy, then the clinician would not receive a cost performance category percent score. However, because CMS has proposed to set the weight of the cost performance category to 0% for the 2020 MIPS payment year, CMS does not propose to redistribute the weight of the cost performance category to any other performance categories for the 2020 MIPS payment year. **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, CMS believes that all MIPS eligible clinicians will have sufficient activities applicable and available. However, CMS proposes a policy for reweighting under extreme and uncontrollable circumstances. Barring these circumstances, CMS does not propose any changes that would affect its ability to calculate an improvement activities performance category score.
- For the ACI performance category, CMS refers readers to its [discussion of ACI proposals](#) for determining when CMS would not score the ACI performance category and would assign a weight of 0% to that category for a MIPS eligible clinician.

CMS invites public comment on this interpretation of sufficient measures available and applicable in the performance categories.

Extreme and Uncontrollable Circumstances (p. 430). In the CY 2017 QPP final rule, CMS established a policy allowing a MIPS eligible clinician affected by extreme and uncontrollable circumstances to submit an application to be considered for reweighting of the ACI performance category. CMS did not propose or finalize a similar reweighting policy for other performance categories in the transition year, but believes a similar reweighting policy may be appropriate for the quality, cost, and improvement activities performance categories beginning with the 2020 MIPS payment year. **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** (for example, 3 months could be considered an extended period of time with regard to information a clinician would collect for the quality performance category). For example, a tornado or fire destroying the only facility in which a clinician practices likely would be considered an “extreme and uncontrollable circumstance;” however, neither the inability to renew a lease – even a long or extended lease – nor a facility being found not compliant with federal, state, or local building codes or other requirements would be considered “extreme and uncontrollable circumstances.”

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. For example, in 2018 the performance period for improvement activities is only 90 days, whereas it is 12 months for the quality performance category, so an issue lasting 3 months may have more impact on the availability of measures for the quality performance category than for the improvement activities performance category, because the MIPS eligible clinician, conceivably, could participate in improvement activities for a different 90-day period.

CMS believes that extreme and uncontrollable circumstances, such as natural disasters, may affect:

- Ability to access or submit quality measures via all submission mechanisms
- Availability of numerous improvement activities
- Performance on measures derived from claims data (such as the all-cause hospital readmission measure and the cost measures), even if case minimums have been met. CMS applies a rationale similar to that used for the Hospital VBP to state that, in some cases, “measures are available to the clinician, but are likely not applicable, because the extreme and uncontrollable circumstance has disrupted practice and measurement processes”

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 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 provides further clarification on the application of this policy, as detailed below:

- Claims-based measures. ***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.***
- Third party intermediaries. ***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.*** Instead, this policy is geared towards events, such as natural disasters, that affect the MIPS eligible clinician’s ability to submit data to the third party intermediary, which in turn, could affect the ability of the clinician (or the third party intermediary acting on their behalf) to successfully submit measures and activities to MIPS.
- 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 also seek comment on what additional factors CMS should consider for virtual groups.***
- APM scoring standard. ***This 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 for several reasons,*** including automatic scoring under the improvement activities category, zero weighting of the cost performance category, and separate quality assessment under each model. MIPS APM entities would be able to request reweighting of the ACI performance category.

CMS requests comment on these proposals. CMS also seeks comment on the types of the extreme and uncontrollable circumstances CMS should consider for this policy given the general parameters CMS describe in this section.

Redistributing Performance Category Weights (p. 435). In cases where there are not sufficient measures and activities applicable and available to score a performance category, CMS will assign different weights under the proposals below. Proposals for the 2020 MIPS payment year are similar to those used in the transition year; however, CMS proposes new scoring policies to incorporate proposals for extreme and uncontrollable circumstances.

CMS proposes redistributions for the 2020 MIPS payment year as follows, assuming CMS’ proposal to weight the cost performance category at 0% are finalized.

- If CMS assigns a weight of 0% for the ACI performance category or for the improvement activities performance category for a MIPS eligible clinician, CMS proposes to continue its policy from the transition year and redistribute the weight of the that category to the quality performance category (assuming the quality performance category does not qualify for reweighting)
- If a MIPS eligible clinician qualifies for reweighting of the quality performance category and the ACI or improvement activity performance categories, then CMS would set the final score at the performance threshold because the final score would be based on one category only, which would not be a composite of two or more performance category scores.
- If a MIPS eligible clinician qualifies for reweighting of the quality performance category, CMS proposes to continue the policy from the transition year and redistribute the 60% weight of the quality performance category so that the performance category weights are 50% for the ACI performance category and 50% for the improvement activities performance category (assuming these performance categories do not qualify for reweighting).

Table 38 and below summarizes the potential reweighting scenarios based on proposals for the 2020 MIPS payment year should the cost performance category be weighted at 0%.

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

Performance Category	Weighting for the 2020 MIPS Payment Year	Reweight Scenario If No ACI Performance Category Score	Reweight Scenario If No Quality Performance Category Percent Score	Reweight Scenario If No Improvement Activities Performance Category Score
Quality	60%	85%	0%	75%
Cost	0%	0%	0%	0%
Improvement Activities	15%	15%	50%	0%
ACI	25%	0%	50%	25%

CMS proposes redistribution of performance category weights for the 2020 MIPS payment year as follows 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 also considered an alternative approach for the 2020 MIPS payment year to redistribute the weight of the ACI performance category to the quality and improvement activities performance categories, to mitigate potential undue emphasis on the quality performance category. For this approach, CMS would redistribute 15% to the quality performance category to obtain a final weight of 75% (60% + 15% = 75%) and 10% to the improvement activities performance category to obtain a final weight of 25% (15% + 10% = 25%), redistributing the weights in increments of 5 points for simplicity. This alternative approach, assuming the cost performance category weight is 0%, is detailed in [Table 39](#). Should the cost performance category have available and applicable measures and the cost performance category weight is not finalized at 0% and the quality performance category is reweighted to 0%, then CMS would redistribute the weight of the ACI performance category to the improvement activities performance category.

CMS invites comments on the proposals for weighting the performance categories for the 2020 MIPS payment year and the alternative option for reweighting the performance category.

MIPS Payment Adjustments ([p. 441](#))

Payment Adjustment Identifier ([p. 441](#)) and Final Score Used in Payment Adjustment Calculation ([p. 442](#))

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.

In the CY 2017 QPP final rule, CMS finalized a policy to use a TIN/NPI's historical performance from the performance period associated with the MIPS payment adjustment. CMS also proposed the following policies, but inadvertently failed to state that CMS were finalizing these policies. ***Thus, CMS clarifies that the following final policies apply beginning with the 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.

In some cases, a TIN/NPI could have more than one final score associated with that same TIN/NPI (not a new TIN) from the performance period, if the MIPS eligible clinician submitted duplicative data sets. In such cases, CMS had previously finalized that the following hierarchy will apply.

- If a MIPS eligible clinician is a participant in MIPS APM, then the APM Entity final score would be used instead of any other final score.

- If a MIPS eligible clinician has more than one APM Entity final score, CMS will apply the highest APM Entity final score to the MIPS eligible clinician.
- If a MIPS eligible clinician reports as a group and as an individual and not as an APM Entity, CMS will calculate a final score for the group and individual identifier and use the highest final score for the TIN/NPI.

Beginning with the 2020 MIPS payment year, CMS proposes to modify the above policies to address the addition of virtual groups.

- 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 policies remain unchanged for TIN/NPIs who are not in an APM Entity or virtual group.

CMS invites public comment on these proposals. [Table 40](#) illustrates the previously finalized and newly proposed policies for determining which final score to use when more than one final score is associated with a TIN/NPI. [Table 41](#) illustrates the previously finalized policies that apply if there is no final score associated with a TIN/NPI from the performance period, such as when a MIPS eligible clinician starts working in a new practice or otherwise establishes a new TIN.

Establishing the Performance Threshold (p. 445)

Under section 1848(q)(6)(D)(i) of the Act, the Secretary is required to compute a performance threshold with respect to which the final scores of MIPS eligible clinicians are compared for purposes of determining the MIPS payment adjustment factors. The performance threshold for a year must be either the mean or median (as selected by the Secretary, and which may be reassessed every 3 years) of the final scores for all MIPS eligible clinicians for a prior period specified by the Secretary, but the Secretary has flexibility to set the performance threshold for the first two years of MIPS. Using this flexibility, CMS finalized a performance threshold of 3 points for the transition year. CMS also stated its intent to increase the performance threshold in the 2020 MIPS payment year, and that, beginning in the 2021 MIPS payment year, CMS would use the mean or median final score from a prior period as required by law.

For the 2020 MIPS payment year, CMS proposes to set the performance threshold at 15 points. However, CMS remains concerned that moving from a performance threshold of 15 points for the 2020 MIPS payment year to a performance threshold of the mean or median of the final scores for all MIPS eligible clinicians for a prior period for the 2021 MIPS payment year may be a steep jump. ***Therefore, CMS also seeks comment on setting the performance threshold either lower or higher than the proposed 15 points for the 2020 MIPS payment year.***

CMS considered an alternative of setting a performance threshold of 6 points, which could be met by submitting two quality measures with required data completeness or one high-weighted improvement activity. CMS also considered an alternative of setting the performance threshold at 33 points, which would require full participation both in improvement activities and in the quality performance category (either for a small group or for a large group that meets data completeness standards) to meet the performance threshold.

CMS invites public comments on the proposal to set the performance threshold at 15 points, and also seeks comment on setting the performance threshold at the alternative of 6 points or at 33 points for the 2020 MIPS payment year. CMS also seeks public comments on principles and considerations for setting the performance threshold beginning with the 2021 MIPS payment year, which will be the mean or median of the final scores for all MIPS eligible clinicians from a prior period.

Additional Performance Threshold for Exceptional Performance (p. 451)

Under Section 1848(q)(6)(D)(ii) of the Act, the Secretary is required to compute, for each year of the MIPS, an additional performance threshold for purposes of determining the additional MIPS payment adjustment factors for exceptional performance. In determining the additional performance threshold, the Secretary is required to apply either of the following methods: (1) the threshold shall be the score that is equal to the 25th percentile of the range of possible final scores above the performance threshold; or (2) the threshold shall be the score that is equal to the 25th percentile of the actual final scores for MIPS eligible clinicians with final scores at or above the performance threshold for a prior period.

For the transition year, CMS established the additional performance threshold at 70 points. ***For the 2020 MIPS payment year, CMS proposes to again set the additional performance threshold at 70 points.⁸ CMS invites public comment on this proposal. CMS also seeks feedback on whether CMS should raise the additional performance threshold to a higher number, which would in many instances require the use of an EHR for those to whom the ACI performance category requirements would apply.***

CMS also seeks public comment on which method CMS should use to compute the additional performance threshold beginning with the 2021 MIPS payment year, given the two methodologies specified above. For example, should CMS use the lower of the two options, which would result in more MIPS eligible clinicians receiving an additional MIPS payment adjustment for exceptional performance? Or should CMS use the higher of the options, which would restrict the additional MIPS payment adjustment for exceptional performance to those with the higher final scores? Since a fixed amount is available for a year to fund the additional MIPS payment adjustments, the more clinicians that receive an additional MIPS payment adjustment, the lower the average clinician's additional MIPS payment adjustment will be.

MIPS Payment Adjustment Factors (p. 445), Scaling/Budget Neutrality Factors (p. 455) and Additional Adjustment Factors (p. 455)

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.

Application of the MIPS Payment Adjustment Factors (p. 455)

CMS previously finalized that the MIPS payment adjustment factors are applied to Medicare Part B payments for items and services furnished by the MIPS eligible clinician during the year. ***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, which is consistent with the approach taken for the value-based payment modifier.*** This would mean that beneficiary cost-sharing and coinsurance amounts would not be affected by the application of the MIPS payment adjustment factor and the additional MIPS payment adjustment factor. The MIPS payment adjustment applies only to the amount otherwise paid under Part B for items and services furnished by a MIPS eligible clinician during a year.

CMS provides an example (see Figure A on [p. 459](#)) of how various final scores would be converted to an adjustment factor (including potentially an additional adjustment factor) using statutory formulas and proposed policies (e.g. performance threshold of 15 points, additional performance threshold of 70 points). CMS also provides three examples of how, under proposed policies, MIPS eligible clinicians can achieve a final score at or above the performance threshold starting on [p. 460](#).⁹

⁸ To set the additional performance threshold at 70, which is not calculated based on one of the two required methods, CMS uses flexibility provided by statute for the initial two years of MIPS.

⁹ Note that CMS confirmed that Example 3, as shown in [Table 45](#), has an error in the calculation of the final score in that it didn't take into account the higher weight of the quality category to be 85%.

Review and Correction of MIPS Final Score (p. 465)

Feedback and Information to Improve Performance (p. 465)

CMS states that they will continue to engage in user research with front-line clinicians to ensure CMS is providing the performance feedback data in a user-friendly format, and that CMS is including the data most relevant to clinicians. Any suggestions from user research would be considered as CMS develops the systems needed for performance feedback, which would occur outside of the rulemaking process. CMS summarizes findings from such research to date on [p. 465](#). Based on that research, CMS has already begun development of real-time feedback on data submission and scoring where technically feasible (some scoring requires all clinician data be submitted, and therefore, cannot occur until the end of the submission period). CMS will continue to provide information for stakeholders who wish to participate in user research via education and communication channels. Suggestions can also be sent via the “Contact Us” information on [qpp.cms.gov](#). However, CMS notes that suggestions provided through this channel will not be considered comments on this proposed rule.

CMS proposes to provide feedback to MIPS participants as follows:

- [MIPS Eligible Clinicians \(p. 466\)](#). ***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, such as quarterly.*** If CMS is able to provide it more frequently, CMS would communicate the expected frequency to stakeholders via education and outreach communication channels. CMS also propose that the measures and activities specified for the CY 2017 performance period (for all four MIPS performance categories), along with the final score, would be included in the performance feedback provided on or about July 1, 2018. ***CMS requests comment on these proposals.***

For cost measures, since CMS can measure performance using any 12-month period of prior claims data, ***CMS requests comment on whether it would be helpful to provide more frequent feedback on the cost performance category using rolling 12-month periods or quarterly snapshots of the most recent 12-month period; how frequent that feedback should be; and the format in which CMS should make it available to clinicians and groups.*** In addition, CMS intends to provide cost performance feedback in the fall of 2017 and the summer of 2018 on new episode-based cost measures that are currently under development by CMS. With regard to the format of feedback on cost measures, CMS is considering utilizing the parts of the Quality and Resource Use Reports (QRURs) that user testing has revealed beneficial while making the overall look and feel usable to clinicians. ***CMS request comment whether that format is appropriate or if other formats or revisions to that format should be used to provide performance feedback on cost measures.***

- [MIPS APMs \(p. 467\)](#). ***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.***
- [Voluntary Reporters \(p. 467\)](#). ***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 requests comments on this proposal.***

Mechanisms (p. 468)

As stated in the CY 2017 QPP final rule, CMS will use a CMS-designated system as the mechanism for making performance feedback available, which CMS expects will be a web-based application. CMS expects to use a new and improved format for the next performance feedback, anticipated to be released around July 1, 2018. It will be provided via the QPP website, and CMS intends to leverage additional mechanisms, such as health IT vendors,

registries, and QCDRs to help disseminate data and information contained in the performance feedback to eligible clinicians, where applicable.

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. Specifically:

- Are there specific health IT functionalities that could contribute significantly to quality improvement?
- Are there specific health IT functionalities that could be part of a certified EHR technology or made available as optional health IT modules in order to support the feedback loop related to Quality Payment Program participation or participation in other HHS reporting programs?
- In what other ways can health IT support clinicians seeking to leverage quality data reports to inform clinical improvement efforts? For example, are there existing or emerging tools or resources that could leverage an API to provide timely feedback on quality improvement activities?
- Are there opportunities to expand existing tracking and reporting for use by clinicians, for example expanding the feedback loop for patient engagement tools to support remote monitoring of patient status and access to education materials?

CMS intends to continue to leverage third party intermediaries as a mechanism to provide performance feedback. Per the policies finalized in the CY 2017 QPP final rule, CMS continues to require qualified registries and QCDRs, as well as encourage other third party intermediaries (such as health IT vendors that submit data to us on behalf of a MIPS eligible clinician or group), to provide performance feedback to individual MIPS eligible clinicians and groups via the third party intermediary with which they are already working. ***CMS also seeks feedback from third party intermediaries on 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.***

Receipt of Information (p. 471)

In the CY 2017 QPP final rule, CMS discussed its intent to explore the possibility of adding functionality that would allow CMS to use the same mechanisms for providing performance feedback to also receive information from professionals. Although CMS is not making any specific proposals at this time, ***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.

Additional Information – Type of Information (p. 471)

Section 1848(q)(12)(B)(i) of the Act states that beginning July 1, 2018, the Secretary shall make available to MIPS 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 by other suppliers and providers of services. This information may be made available through mechanisms determined appropriate by the Secretary, such as the CMS-designated system that would also provide performance feedback. Section 1848(q)(12)(B)(ii) of the Act specifies that the type of information provided may include the name of such providers, the types of items and services furnished, and the dates that items and services were furnished. Historical data regarding the total, and components of, allowed charges (and other figures as determined appropriate by the Secretary) may also be provided.

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.

Performance Feedback Template (p. 473)

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. Additionally, CMS understands the term “performance feedback” may not be meaningful to clinicians or groups to clearly denote what this data might imply. **Therefore, CMS seeks comment on what to term “performance feedback.”** User testing to date has provided some considerations for a name in the Quality Payment Program, such as Progress Notes, Reports, Feedback, Performance Feedback, or Performance Reports. Any suggestions on the template to be used for performance feedback or what to call “performance feedback” can be submitted to the Quality Payment Program website at qpp.cms.gov.

Targeted Review (p. 474)

CMS does not propose any changes to the targeted review process, but provides information on policies finalized in the CY 2017 QPP final rule, starting on [p. 474](#).

Data Validation and Auditing (p. 475)

In the CY 2017 QPP final rule, CMS finalized several policies related to data validation and auditing, including selective auditing and compliance requirements. In some cases, CMS codified requirements in regulation text, but in others, CMS did not. Additionally, CMS has identified additional oversights in its final policies. As such, **CMS proposes to codify policies below in regulation text, as well as make 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.

Third Party Data Submission (p. 478)

CMS clarifies in this section that MIPS data may be submitted by third party intermediaries on behalf of an individual MIPS eligible clinician, group, or *virtual group*.

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 also seeks comment on the following questions and other ideas to further advance the role of third-party intermediaries for clinicians in both MIPS and APMs and to reduce clinician burden by enabling a streamlined reporting and feedback system:

- Should it consider implementing additional incentives for eligible clinicians to use a third-party intermediary which has demonstrated substantial participation from additional payers and/or other clinical data sources across practices caring for a cohort of Medicare beneficiaries within a given geographic area?
- Should these incentives also include expectations that structured, standardized data be shared with third party intermediaries?
- Should there be additional refinements to the approach to qualifying third party intermediaries which evaluate the degree to which these intermediaries can deliver longitudinal information on a patient to participating clinicians?
- Should there be a special designation for registries that would convey the availability of longitudinal clinical data for robust measurement and feedback?

Qualified Clinical Data Registries (QCDRs) (p. 480)

Establishment of an Entity Seeking to Qualify as a QCDR (p. 480)

CMS does not propose any changes to these criteria.

Self-Nomination Period (p. 480)

In the 2017 QPP final rule (81 FR 77365 through 77366), CMS finalized the self-nomination period for the 2018 performance period and for future years of the program to be from September 1 of the year prior to the applicable performance period until November 1 of the same year (i.e., September 1, 2017 through November 1, 2017 for the 2018 performance period).

Recognizing that some QCDRs have no changes to the measure and/ or activity inventory from year to year, ***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.*** In addition, the existing QCDRs may decide to make minimal changes to their approved self-nomination application from the previous year, which would be submitted by the QCDR for CMS review and approval by the close of the self-nomination period. These may include limited changes to their performance categories, adding or removing MIPS quality measures, and adding or updating existing services and/or cost information. Existing QCDRs in good standing, may also submit for CMS review and approval, substantive changes to measure specifications for existing QCDR measures that were approved the previous year, or submit new QCDR measures for CMS review and approval without having to complete the entire self-nomination application process, which is required to be completed by a new QCDR. By attesting that certain aspects of their approved application from the previous year have not changed, existing QCDRs in good standing would be spending less time completing the entire self-nomination form, as was previously required on a yearly basis.

CMS clarifies that substantive changes to existing QCDR measure specifications or any new QCDR measures would have to be submitted for CMS review and approval by the close of the self-nomination period.

CMS seeks comment on an alternative policy of offering a multi-year approval, where QCDRs would be

approved for a 2-year increment of time. CMS is concerned this would not provide the QCDR with the flexibility to add or remove services and/or measures or activities based on their QCDR capabilities for the upcoming program year. CMS also has concerns regarding QCDRs who perform poorly during the first year, and who should be placed on probation or disqualified.

For future years, beginning with the 2018 performance period, CMS proposing that self-nomination information must be submitted via a web-based tool, and to eliminate the submission method of email.

Information Required at the Time of Self-Nomination (p. 483)

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.

QCDR Criteria for Data Submission (p. 483)

While CMS does not propose any changes to the criteria for data submission in this proposed rule, it would like to note the following as clarifications to existing criteria. Specifically, a QCDR:

- Must have in place mechanisms for the transparency of data elements and specifications, risk models, and measures. CMS expects that the QCDR measures, and their data elements (i.e., specifications) comprising these measures be listed on the QCDR’s website unless the measure is a MIPS measure. QCDR measure specifications should be provided at a level of detail that is comparable to what is posted by CMS on the CMS website for MIPS quality measures specifications. CMS also clarifies in the next section that a QCDR must publicly post the measure specifications no later than 15 calendar days following CMS’ approval of these measures specifications.
- Approved QCDRs may post the MIPS quality measure specifications on their website, if they so choose. If the MIPS quality measure specifications are posted by the QCDRs, they must replicate exactly the same as the MIPS quality measure specifications posted on 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 the 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. CMS refers readers to this [section of the rule](#) for additional information on third party intermediaries and performance feedback.
- For purposes of distributing performance feedback to MIPS eligible clinicians, CMS encourages QCDRs to assist MIPS eligible clinicians in the update of their email addresses in CMS systems – including PECOS and the Identity and Access System - so that they have access to feedback as it becomes available on www.qpp.cms.gov and have documentation from the MIPS eligible clinician authorizing the release of his or her email address.

As previously established, CMS will, on a case-by-case basis allow QCDRs and qualified registries to request review and approval for additional MIPS measures throughout the performance period; however, QCDRs will not be able to request additions of any new QCDR measures throughout the performance period. QCDRs will not be able to retire any measures they are approved for during the performance period. Should a QCDR encounter an issue regarding the safety or change in evidence for a measure during the performance period, they must inform CMS of said issue and CMS will review measure issues on a case-by-case basis.

QCDR Measure Specifications Criteria (p. 485)

CMS generally intends to apply a process similar to the one used for MIPS measures to QCDR measures that have been identified as topped out.

It does not propose any changes to the QCDR measure specifications criteria as finalized in the 2017 QPP rule. For QCDR quality measures, CMS encourages alignment with its measures development plan, but will consider all QCDR measures submitted by the QCDR. However, CMS will likely not approve retired measures that were previously in one of CMS's quality programs, such as the PQRS, if proposed as QCDR measures. This includes measures that were retired due to being topped out.

CMS seeks comment on, in the future, potentially requiring QCDRs that develop and report on QCDR measures to fully develop and test (i.e., conduct reliability and validity testing) their QCDR measures, by the time of submission of the new measure during the self-nomination process.

Also, ***beginning with the 2018 performance period and for future program years, CMS proposes that QCDR vendors may seek permission from another QCDR to use an existing measure that is owned by the other QCDR.*** If a QCDR would like report on an existing QCDR measure that is owned by another QCDR, they must, by the time of self-nomination, have permission from the QCDR that owns the measure that they can use the measure for the performance period.

Collaboration of Entities to Become a QCDR ([p. 487](#))

CMS does not propose any changes to this policy in this proposed rule.

Health IT Vendors That Obtain Data from MIPS Eligible Clinicians' Certified EHR Technology (CEHRT) ([p. 487](#))

CMS does not propose any changes to this policy in this proposed rule. ***However, it 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.***

Qualified Registries ([p. 488](#))

CMS does not propose any changes to the definition or the capabilities of qualified registries in this final rule, nor to the criteria regarding the establishment of an entity seeking to qualify as a registry.

Similar to the process proposed for QCDRs, ***CMS proposes, beginning with the 2019 performance period, a simplified 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.*** This process would be conducted on a yearly basis, from September 1 of the year prior to the applicable performance period until November 1 of the same year, starting in 2018, aligning with the annual self-nomination period in order to ensure that only those qualified registries who are in good standing utilize this process.

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.

CMS does not propose any changes to the information required at the time of self-nomination.

CMS-Approved Survey Vendors ([p. 493](#))

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 in QPP year 2 and future years that the vendor application deadline would be January 31st of the applicable performance year or a later date specified by CMS, rather than April 30th.

Probation and Disqualification of a Third Party Intermediary (p. 494)

CMS does not propose any changes to the process of probation and disqualification of a third party intermediary in this proposed rule. However, CMS clarifies that 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 cases of vendors leaving the marketplace during the performance period on a case-by-case basis.

CMS will take into consideration in future rulemaking requests that it provide opportunities for MIPS eligible clinicians and groups that discover an issue with their third party intermediary to change reporting methods and/or third party intermediaries without restriction on the eligible clinicians.

Auditing of Third Party Intermediaries Submitting MIPS Data (p. 496)

CMS previously finalized that third party intermediaries (i.e., a QCDR, health IT vendor, qualified registry, or CMS-approved survey vendor) must comply with certain procedures, including retaining all data submitted to us for MIPS for a minimum of 10 years (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). ***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.***

Public Reporting on Physician Compare (p. 498)

Background

As required under section 10331(a)(1) of the Affordable Care Act (ACA), CMS developed a Physician Compare Internet website in late 2010 with information on physicians enrolled in the Medicare program, as well as information on other EPs who participate in the PQRS. More information about Physician Compare can be accessed on the [Physician Compare Initiative website](#).

CMS discusses in this section its phased approach to public reporting of performance data. The first set of quality measures were publicly reported on Physician Compare in February 2014. Currently, the site publicly reports:

- 91 group-level measures collected through either the Web Interface or registry for groups participating in 2015 under the PQRS;
- 19 quality measures for ACOs participating in the 2015 Shared Savings Program or Pioneer ACO program;
- 90 individual clinician-level measures collected either through claims or registry for individual EPs participating in 2015 under the PQRS;
- 31 total individual clinician-level QCDR non-PQRS measures are publicly available either through Physician Compare profile pages or 2015 QCDR websites

As finalized in the CY 2015 and CY 2016 PFS final rules (79 FR 67547 and 80 FR 70885, respectively), Physician Compare will continue to expand public reporting. This expansion includes publicly reporting both 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 benchmark and 5-star rating in late 2017 based on 2016 data (80 FR 71125 and 71129).

This expansion will continue under the MACRA. Sections 1848(q)(9)(A) and (D) of the Act requires CMS to make available on the Physician Compare website, 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;

- 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.

In this section, CMS reviews public reporting standards that have been identified in the ACA (e.g., reporting only on data that are statistically valid and reliable data that are accurate and comparable), as well as standards set by CMS (e.g., only disclosing data on physician profile pages that resonates with and can be accurately interpreted by the public, as determined through user testing; not reporting on a cost or quality measure in its first year of use). It also discusses its policy to extend the current Physician Compare 30-day preview period for MIPS eligible clinicians starting with data from the 2017 MIPS performance period, which will be available for public reporting in late 2018.

Also, 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 the utilization of items and services furnished to people with Medicare. CMS 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 that is available to the public, such as an NPI.

The information is further required to be made searchable by at least specialty or type of physician or other eligible clinician; characteristics of the services furnished (such as, volume or groupings of services); and the location of the physician or other eligible clinician.

CMS finalized a policy in the CY 2016 PFS final rule (80 FR 71130) to add utilization data to the Physician Compare downloadable database. Utilization data are currently available [here](#). This information will be 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. Not all available data will be included. The specific HCPCS codes included are to be determined based on analysis of the available data, focusing on the most used codes. Additional details about the specific HCPCS codes that are included in the downloadable database will be provided to stakeholders in advance of data publication. Again, all data available for public reporting – on the public-facing website pages or in the downloadable database – are available for review during the 30-day preview period.

Final Score, Performance Categories, and Aggregate Information (p. 504)

Per the MACRA mandates cited above, CMS requests comment on its proposal to publicly report on Physician Compare the final score for each MIPS eligible clinician or group, performance of each MIPS eligible clinician or group for each performance category, and periodically post aggregate information on the MIPS, including the range of final scores for and the range of performance of all the MIPS eligible clinicians or groups for each performance category, as technically feasible.

Quality (p. 505)

As previously finalized, all measures in the quality performance category that meet the statistical public reporting standards will be included in the downloadable database, as technically feasible. A subset of these measures will be publicly reported on the website's profile pages, as technically feasible, based on website user testing.

Recognizing that it will continue its policies of not publicly reporting first year quality measures, only reporting

those measures that meet reliability thresholds¹⁰ and meet public reporting standards, and including the total number of patients reported on for each measure in the downloadable database, CMS again proposes to make all measures under the MIPS quality performance category available for public reporting on Physician Compare, as technically feasible. This would include all available measures reported via all available submission methods for both MIPS eligible clinicians and groups, for 2018 data available for public reporting in late 2019, and for each year moving forward. CMS requests comment on this proposal.

In addition, ***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.*** This proposal was discussed earlier in the quality performance category section and would be considered for future rulemaking.

Cost (p. 508)

As required under MACRA and discussed in the final rule (81 FR 77395), cost data are difficult for patients to understand and, as a result, publicly reporting these measures could lead to significant misinterpretation and misunderstanding. For this reason, ***CMS again proposes to include on Physician Compare a sub-set of cost measures that meet the public reporting standards, either on profile pages or in the downloadable database, if technically feasible, for 2018 data available for public reporting in late 2019, and for each year moving forward.*** Previously established standards regarding first year measures, the minimum reliability threshold, and all public reporting standards would apply here. This proposal also would apply to all available measures reported via all available submission methods, and to both MIPS eligible clinicians and groups.

Improvement Activities (p. 510)

Consistent with the policy finalized for the transition year, ***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, for 2018 data available for public reporting in late 2019, and for each year moving forward.*** This again includes all available activities reported via all available submission methods, and applies to both MIPS eligible clinicians and groups. For those eligible clinicians or groups that successfully meet the improvement activities performance category requirements this information may be posted on Physician Compare as an indicator.

This information is required by the MACRA to be available for public reporting on Physician Compare, but since improvement activities performance category is a new field of data for Physician Compare, ***CMS proposes that statistical testing and user testing would determine how and where improvement activities are reported on Physician Compare.***

Given that completion of or participation in activities the first year they are available is different from reporting first year quality or cost measures, ***CMS proposes publicly reporting first year activities if all other reporting criteria are satisfied starting with year two (2018 data available for public reporting in late 2019).***

Advancing Care Information (p. 511)

Since the beginning of the EHR Incentive Programs in 2011, participant performance data has been publicly available in the form of public use files on the CMS website. However, at this time there is only an indicator on

¹⁰ Currently, there is a minimum sample size requirement of 20 patients for performance data to be included on Physician Compare. However, CMS finalized instituting a minimum reliability threshold for public reporting data on Physician Compare starting with 2017 data available for public report in late 2018 and each year moving forward (81 FR 77395). CMS clarifies that reliability standards for public reporting and reliability for scoring need not align. Reliability for public reporting is unique in that it requires additional protections to maintain confidentiality. Since publicly reported measures can be compared across clinicians and across groups, it also is particularly important that the most stringent standards be in place to ensure differences in performance scores reflect true differences in quality of care to promote accurate comparisons by the public.

Physician Compare profile pages to show that an eligible clinician successfully participated in the current Medicare EHR Incentive Program.

Consistent with its transition year final policy, ***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 proposals would apply to 2018 data available for public reporting in late 2019, and for each year moving forward, as this information is required by the MACRA to be available for public reporting on Physician Compare.*** Any ACI objectives, activities, or measures would need to meet the public reporting standards applicable to data posted on Physician Compare. Again, statistical testing and website user testing would determine how and where objectives and measures are reported on Physician Compare. ***As with improvement activities, CMS proposes to allow first year ACI objectives, activities, or measures.***

Achievable Benchmark of Care (ABC™) (p. 512)

CMS previously finalized (80 FR71129) a decision to publicly report on Physician Compare an item, or measure-level, benchmark using the Achievable Benchmark of Care (ABC™) methodology annually based on the PQRS performance rates most recently available by reporting mechanism.

In this rule, ***CMS again 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 for each year of the QPP, starting with the transition year data (2017 data available for public reporting in late 2018). CMS also proposes to use this benchmark to determine a 5-star rating for each MIPS measure, as feasible and appropriate.*** The details of how the benchmark will be specifically used to determine the 5-star categories for all applicable measures is being determined in close collaboration with stakeholders, measure experts, and the Physician Compare Technical Expert Panel. However, as previously finalized, the benchmark will only be applied to those measures deemed to meet the established public reporting standards and the benchmark would be based on the most recently available data.

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 specific measures the benchmark will be calculated for will be determined once the data are available and analyzed.

The ABC™ methodology produces a benchmark that represents the best care provided to the top 10% of patients by measure, by reporting mechanism. An example is provided below:

A clinician reports on how many patients with diabetes she has given foot exams. There are four steps to establishing the benchmark for this measure:

- 1) CMS would look at the total number of patients with diabetes for all clinicians who reported this diabetes measure.
- 2) CMS would rank clinicians that reported this diabetes measure from highest performance score to lowest performance score to identify the set of top clinicians who treated at least 10% of the total number of patients with diabetes.
- 3) CMS would count how many of the patients with diabetes who were treated by the top clinicians also got a foot exam.
- 4) This number would be divided by the total number of patients with diabetes who were treated by the top clinicians, producing the ABC™ benchmark.

The benchmarks for Physician Compare developed using the ABC™ methodology will be based on the current

year's data.

To account for low denominators, ***CMS will use a beta binomial model adjustment, which moves extreme values toward the average for a given measure (versus the alternative, a Bayesian Estimator, which moves extreme values toward 50%).*** CMS believes that the beta binomial method is a more methodologically sophisticated approach to address the issue of extreme values based on small sample sizes, which ensures that all clinicians are accounted for and appropriately figured in to the benchmark.

CMS recognizes stakeholder requests for a more consistent approach to benchmarking across the QPP program. However, CMS has found that the benchmark and decile breaks used to assign and determine MIPS payment are not ideal for public reporting for several reasons, including the fact that the decile approach, when used for public reporting, would force a star rating distribution inconsistent with the raw distribution of scores on a given measure. In other words, with the ABC™ methodology, if the majority of clinicians performed well on a measure, the majority would receive a high star rating. However, if CMS used the decile approach some clinicians would be reported as having a “low” star rating despite their relative performance on the measure. CMS reminds readers that it is not always ideal to apply the same methodologies across the program and that a key consideration for public reporting is that the methodology used best helps patients and caregivers easily interpret the data accurately.

Voluntary Reporting (p. 517)

In response to earlier feedback, ***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 two 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.** If clinicians and groups do not actively opt out at this time, their data would be available for inclusion on Physician Compare if the data meet all previously stated public reporting standards and the minimum reliability threshold.

Publicly Reported APM Data (p. 518)

Section 1848(q)(9)(A)(ii) of the Act requires us to publicly report names of eligible clinicians in Advanced APMs and, to the extent feasible, the names and performance of Advanced APMs. CMS sees this as an opportunity to continue to build on the ACO reporting it is now doing on Physician Compare. As such, ***CMS again proposes to publicly report names of eligible clinicians in Advanced APMs and the names and performance of Advanced APMs and APMs that are not considered Advanced APMs related to the QPP starting with year two 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.***

Stratification by Social Risk Factors (p. 519)

CMS seeks comment on, potentially in the future, accounting for social risk factors through public reporting on Physician Compare, including:

- Comments on stratifying public reporting by risk factors
- Feedback on which social risk factors or indicators should be used and from what sources
- Feedback on the process for accessing or receiving the necessary data to facilitate stratified reporting.
- Comments on whether strategies such as confidential reporting of stratified rates using social risk factor indicators should be considered in the initial years of the QPP in lieu of publicly reporting stratified performance rates for quality and cost measures under the MIPS on Physician Compare.

Board Certification (p. 520)

CMS proposes to add the American Board of Wound Medicine and Surgery (ABWMS) Certification information to Physician Compare. CMS currently includes ABMS, AOA, and ABO data as part of clinician profiles on Physician Compare.

For all years moving forward, CMS proposes to establish a process for reviewing interest from boards these boards on a case-by-case basis. For purposes of CMS's selection, 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. Boards would have to contact the Physician Compare support team at PhysicianCompare@Westat.com to indicate interest and initiate the review and discussion process. Once decisions are made, they will be communicated via the CMS.gov Physician Compare initiative webpage and via the Physician Compare listserv.

Overview of the APM Incentive ([p. 523](#))

Definitions and Regulatory Text Changes ([p. 523](#))

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
- Alter:
 - **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) ([p. 524](#)).
 - **APM Entity:** CMS proposes to revise the definition to clarify that a payment arrangement with a non-Medicare payer is an Other Payer Arrangement ([p. 525](#)).
 - **Medicaid APM:** CMS proposes to make technical changes to the definition to clarify that these arrangements must meet the Other Payer Advanced APM criteria ([p. 525](#)).
 - **Advanced APM Entity:** CMS proposes to replace Advanced APM Entity where it appears through the regulations with “APM Entity” ([p. 525](#)).
 - **Advanced APM Entity Group:** CMS proposes to replace Advanced APM Entity Group with “APM Entity “group” where it appears in regulation ([p. 525](#)).
 - **Monitoring and Program Integrity Provisions (§414.1460):** CMS makes changes to the regulatory text to reflect policies discussed elsewhere in the proposed rule ([p. 526](#)).
 - CMS is revising the language to distinguish between scenarios of rescinding QP determinations and recouping APM Incentive Payments given that they are separate policies ([p. 526](#)).
 - CMS is revising when it may rescind a QP determination ([p. 526](#)).
 - 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 ([p. 527](#)).
 - CMS is streamlining provisions directed at reducing or denying APM incentive payments to clinicians or APM Entities who are terminated from an APM ([p. 527](#)).

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.” (p. 525). CMS also proposes several technical corrections and typographical errors beginning on p. 525.

Advanced APM Criteria: Financial Risk (p. 528)

Nominal Amount of Risk

In order to be considered an Advanced APM, the APM must either require that participating APM Entities bear risk for monetary losses of a “more than nominal amount” under the APM (or be a Medical Home Model expanded under section 1115A(c) of the Act). CMS previously finalized two ways in which an APM can meet the Nominal Amount standard. An APM would meet the Nominal Amount standard if under the terms of the APM, the total amount that an APM Entity potentially owes CMS or forgoes is at least:

- **Revenue-Based Standard.** For QP Performance Periods in 2017 and 2018: 8% of the average estimated total Medicare Parts A and B revenues of participating APM Entities.
 - **Percentage.** CMS previously requested comment on increasing this standard for the third and subsequent QP Performance Periods, in particular on setting the level at 15% of revenue or alternatively, setting it at 10% so long as risk is at least equal to 1.5% of expected expenditures for which an APM entity is responsible under an APM.
 - Based on comments received, ***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*** (p. 533).
 - CMS will address the policy for performance periods after 2020 in subsequent rulemaking, but requests comment on the amount and structure of the Revenue-Based Standard for 2021 and later.
 - ***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.*** This comment request is both for whether the separate standard would apply only to small and rural practices that are participants in an APM or whether it should also apply to small and rural practices that join larger APM Entities in order to participate in an APM (p. 543).
 - **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”*** (p. 531). 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 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.” (p. 532).
- ***Benchmark-Based Standard:*** For all QP Performance Periods: 3% of the expected expenditures for which an APM entity is responsible under the APM. (For episode payment models, “expected expenditures” means the target price for an episode).

Medical Home Model Variation

- **Financial Risk.** CMS previously finalized that for a Medical Home Model to meet the Financial Risk Criterion to be an Advanced APM it must include provisions that potentially:
 - Withhold payment for services to the APM Entity and/or the APM Entity's Eligible Clinicians;
 - Reduce payment rates to the APM Entity and/or the APM Entity's Eligible Clinicians;
 - Require the APM Entity to owe payment(s) to CMS; or
 - Lose the right to all or part of an otherwise guaranteed payment or payments, if either:
 - Actual expenditures for which the APM Entity is responsible under the APM exceed expected expenditures during a specified performance period; or
 - APM Entity performance on specified performance measures does not meet or exceed expected performance on such measures for a specified performance period (Unlike the generally applicable financial risk standard, a Medical Home Model would be able to meet the requirements even if the financial risk arrangement only included potential reductions in bonus payments.)
- **Nominal Amount.** In addition, CMS previously finalized the Medical Home Model "Nominal Amount" Standard. In the case of Medical Home Models, the risk percentages are based on Medicare Parts A and B revenue. CMS finalized that the percentages must be at least:
 - 2018: 3% of the APM Entity's total Medicare Parts A and B revenue (up from 2.5% in 2017)
 - 2019: 4% of the APM Entity's total Medicare Parts A and B revenue.
 - 2020 and later: 5% of the APM Entity's total Medicare Parts A and B.

In response to concerns about the rate of increase in the Medical Home Model Nominal Amount Standard, ***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 also previously finalized that if the financial risk arrangement under a Medical Home Model is not based on revenue (e.g. based on total cost of care or a per beneficiary per month dollar amount), CMS will make a determination of risk compared to the average estimated total Parts A and B revenue of its participating APM Entities using most recently available data.)

- **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+) (p. 530).*** CMS believes applicants applying in Round 1 were not necessarily aware of the policy and would have already participated in CPC+ for one year without the requirement applying. In order to provide adequate notice and clarification, ***CMS proposes that CPC+ participants who enroll in the future will not be exempt from this requirement (p. 530).***

Qualifying APM Participant (QP) and Partial QP Determination (p. 538)

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 (p. 538).

- **Advanced APMs Starting or Ending During a Medicare QP Performance Period.**¹¹ CMS states that it believe 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 receive of a performance-based payment (p. 538). **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 (p. 539).** CMS is concerned that this puts APM Entities that join an Advanced APM that starts after January 1 or ends before August 31 at a disadvantage because the payment amount or patient count denominator for an APM Entity could include a period of time in which the entity was not participating in the Advanced APM. **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 (p. 540).**^{12,13,14} **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.**
- **Participation in Multiple Advanced APMs.** CMS seeks to clarify its policy for making QP and Partial QP determinations for eligible clinicians in more than one APM Entity group where none of the APM Entity groups achieve QP or Partial QP status. CMS previously finalized a policy for instances where an eligible clinician participates in multiple Advanced APMs:
 - That if one or more of the Advanced APM Entities in which the eligible clinician participates meets the QP threshold, the eligible clinician becomes a QP;
 - That if none of the Advanced APM Entities in which the eligible clinician participates meet the QP threshold, CMS will assess the eligible clinician individually using combined information for services associated with that individual’s NPI and furnished through all such eligible clinician’s Advanced APM Entities during the QP Performance Period.
 - CMS will use a methodology so that services are not double-counted (e.g., a surgeon participating in a bundled payments model, in which some of the procedures are performed on patients affiliated with an ACO that the surgeon is also a part of, would only have payments or patients from those procedures count once towards the QP determination).

CMS proposes to clarify that if an eligible clinician is determined to be a QP or Partial QP based on

¹¹ CMS notes that this policy does *not* apply to Other Payer Advanced APMs because CMS believes eligible clinicians have more control of participation dates of payment arrangements with Other Payers than they do with Medicare start and end dates which are exclusively set by CMS (p. 542).

¹² CMS notes that this will not affect how it makes QP and Partial QP determinations for individual eligible clinicians who participate in multiple Advanced APMs: CMS will continue to review the full Medicare QP Performance Period for that individual eligible clinician even if one of the Advanced APMs in which he or she participated started or ended in the middle of the Medicare QP Performance Period (p. 540).

¹³ This policy does not apply to APM Entities that had the *option* to participate in the Advanced APM track of a model during the entire Medicare QP Performance Period but chose not to until later in the year (e.g. a participant in the Oncology Care Model that does not switch to two-side risk until later in the year) (p. 543).

¹⁴ CMS stated that it need not apply this policy to the Comprehensive Care for Joint Replacement (CJR) Model because it has already determined that CJR- CEHRT Track (Track 1) will include episodes ending on or after January 1, 2017 and therefore did not start after the beginning of a QP Performance Period (p. 543).

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) (p. 544).

All-Payer Combination Option (p. 546)

Overview

MACRA creates a mechanism for also qualifying as a QP via the Combination All-Payer Threshold beginning in Payment Year 2021. CMS refers to this as the “All-Payer Combination Option.” CMS reviewed some of its previously finalized provisions (p. 546).

- **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).
- **Payment Amount and Patient Counts.** CMS finalized the annual All-Payer Combination Option QP payment amount and patient count thresholds which are reviewed in [Table 46](#) and [Table 47](#), beginning with Payment Year 2021.

Other Payer Advanced APM Criteria (p. 549)

CMS previously finalized that an Other Payer arrangement (other than traditional Medicare) will be an Other Payer Advanced APM if it meets the following three criteria:

- **CEHRT.** The Other Payer arrangement requires at least 50% of participating eligible clinicians in each APM Entity to use CEHRT “to document and communicate clinical care.” CMS believes that some Other Payer arrangements may only require CEHRT use at the individual Eligible Clinician level in a contract that the Eligible Clinicians has with the payer, and CMS is concerned that it might be challenging for Eligible Clinicians to submit information that would help CMS to determine whether at least 50% of Eligible Clinicians under the payment arrangement are required to use CEHRT to document and communicate clinical care. Therefore, **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) (p. 603).**
- **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.¹⁵
- **“More than Nominal Financial Risk.”** The other payer arrangement either: (1) requires APM Entities to bear more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures (under either the generally applicable or Medicaid Medical Home Model standards for nominal amount of financial risk, as applicable); or (2) is a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Act.

CMS previously finalized policies to assess the Financial Risk criterion for Other Payer Advanced APMs:

¹⁵ CMS previously finalized the requirement that in order to meet the quality measure Other Payer Advanced APM criteria, the payment arrangement must use an outcome measure if there is an applicable one on the MIPS quality measure list, and if there is not a measure available for use in the payment arrangement that the APM must attest that there are no applicable measures on the MIPS quality measure list. CMS also acknowledge that there is a lack of appropriate outcome measures for use by certain specialties. CMS did not propose changes to this policy but makes technical changes to clarify that payers, APM Entities, or Eligible Clinicians must certify that there is no applicable quality measure on the MIPS quality measure list if the payment arrangement does not use an outcome measure (p. 602).

- Financial Risk Standard: CMS finalized that the generally applicable financial risk standard for Other Payer Advanced APMs would be that a payment arrangement must, if an APM Entity actual aggregate expenditures exceeded expected aggregate expenditures during a specified performance period:
 - Withhold payment for services to the APM Entity and/or the APM Entity’s eligible clinicians;
 - Reduce payment rates to the APM Entity and/or the APM Entity’s Eligible Clinicians; or
 - Require direct payments by the APM Entity to the payer.
- Nominal Amount Standard¹⁶:
 - 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 for Other Payer Advanced APMs (p. 555).**
 - Minimum Loss Rate (MLR) of no greater than 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 (p. 555).**
 - 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.¹⁷ **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 (p. 556).** 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).¹⁸ 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) (p. 556).
 - **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.**

¹⁶ CMS noted that while the MLR and Marginal Risk components are not required under the Advanced APM criteria, all current Advanced APMs would have met the requirements. Therefore, CMS does not believe the addition of these criteria for Other Payer Advanced APMs will producing “meaningfully different results in terms of actual risk faced by participants.” (p. 554).

¹⁷ The criterion as finalized in 2017 included only the Benchmark-Based Standard for determining Nominal Risk and not the Revenue-Based Standard as finalized for Advanced APMs (p. 554). CMS includes a comparison of the generally applicable Advanced APM Nominal Amount Standard and the Other Payer Advanced APM Nominal Amount Standard in Table 48.

¹⁸ CMS expressed concern about its ability to assess whether an Other Payer arrangement meets the Revenue-Based Nominal Amount Standard: “We do not have direct access to other payer revenue data, so we could not do this calculation without significant assistance from the relevant payer. For this reason, **we propose that the revenue-based standard would only be applied to other payer arrangements in which risk is explicitly defined in terms of revenue, as specified in an agreement covering the other payer arrangement.**” (Emphasis added) (p. 556).

- ***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*** ([p. 557](#)).
- ***CMS Seeks Comment on whether, for Performance Years 2019 and 2020, it should consider a different Revenue-Based Nominal Amount Standard 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”*** ([p. 557](#)).

Other Payer Medical Home Models ([p. 550](#))

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*** ([p. 551](#)):

- 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)

Other Payer Medical Home Model: Financial Risk. It is also noted that ***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)*** ([p. 552](#)).

Other Payer Medical Home Model: Additional Information Request: CMS is interested in comments on ([p. 552](#)):

- Whether there are payment arrangements that exist 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 Homes

Medicaid Medical Home: Final Risk “Nominal Amount” Standard ([p. 557](#)). CMS 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 is 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 (p. 559):**

- **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**

Determination of Other Payer Advanced APMs (p. 560)

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 sufficient payments or patients attributed to a combination of participation in Advanced APMs and Other Payer Advanced APMs.

CMS makes several proposals to further implement these policies.

Payer Initiated Other Payer Advanced APM Determination Process (“Payer Initiated Process”) (p. 561).

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 (p. 561). The process is voluntary.

- 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 (p. 562).**
- **CMS proposes that Other Payer Advanced APM determination would be in effect for only one year at a time (p. 562).** The payers would need to submit payment arrangement information each year.

Payer Initiated Process Proposals	
Guidance and Submission Form (p. 563)	<p>CMS will make guidance available regarding the Payer Initiated Process <u>for each payer type</u> prior to the first Submission Period (2018).</p> <p>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 proposes that payers would be required to use the Payer Initiated Submission Form to request an Other Payer Advanced APM determination.</p> <p>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 will allow for attachment of supporting documentation. CMS proposes that payers may submit requests for review of multiple other payer arrangements through the Payer Initiated Process (using separate forms). CMS will make a separate determination as to each other payer arrangement. However, payers may submit Other Payer</p>

Payer Initiated Process Proposals

arrangements with different tracks within that arrangement as one request along with information specific to each track.

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 ([p. 571](#)). 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. As states begin discussions with CMS regarding the development of other payer arrangements through the different legal authorities available under Title XIX or Title XI of the Act, CMS would help states consider and address the Other Payer Advanced APM criteria ([p. 573](#)).

CMS Multi-Payer Models: CMS will make guidance available regarding the Payer Initiated Process for other payer arrangements in CMS Multi-Payer Models prior to the first Submission Period (2018) ([p. 577](#)).

Medicare Health Plans: CMS make guidance available for Medicare Health Plan payment arrangements prior to the first Submission Period (2018). CMS will make guidance available on or around the time of release of the Part C and D Advance Notice and Draft Call Letter the year prior to the relevant All-Payer QP Performance Period ([p. 584](#)). CMS notes that the submission form would be built into the Health Plan Management System (HPMS), which payers currently use for the 585 annual bidding process ([p. 585](#)).

Submission Form Content
([p. 596](#))

CMS proposes to require that payers submit the following information for each other payer arrangement:

- Arrangement name;
- Brief description of the nature of the arrangement;
- Term of the arrangement (anticipated start and end dates);
- Participant eligibility criteria¹⁹;
- Locations (nationwide, state, or county) where this other payer arrangement will be available;
- Evidence that the CEHRT criterion is satisfied;
- Evidence that the quality measure criterion is satisfied (including an outcome measure²⁰);
- 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 proposes that a submission for an Other Payer Advanced APM determination is complete only if all of these elements are submitted.

Submission Period
([p. 563](#))

CMS proposes 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.

Medicaid: ***CMS proposes 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***

¹⁹ In order to assess whether Medicaid APMs and Medicaid Medical Home Models are “available” for participation in order to calculate the QP threshold score denominators, CMS noted elsewhere in the rule that this would include requesting information about Medicaid APMs and Medicaid Medical Home Models and which specialties are eligible to participate ([p. 625](#)).

²⁰ Additional information on the certification of whether an outcome measure is available can be found on [p. 602](#).

Payer Initiated Process Proposals

	<p><i>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. CMS proposes 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. 572).</i></p> <p><i>CMS Multi-Payer Models: CMS proposes that the submission period would open on January 1 of the calendar year prior to the relevant All-Payer QP Performance Period. CMS proposes that the submission period would close on June 30 of the calendar year prior to the relevant All-Payer QP Performance Period (p. 578).</i></p> <p><i>Medicare Health Plans: CMS proposes that the Submission Period would begin and end at the same time as the annual bid timeframe. CMS proposes 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. 585).</i></p>
<p>CMS Determination (p. 564)</p>	<p>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. <i>CMS proposes 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 no later than 10 business days from the date informed.</i> 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. <i>These determinations are final and not subject to reconsideration.</i></p> <p><i>Medicaid: CMS proposes 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 10 business days from the date we inform the state.</i> 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. <i>These determinations are final and not subject to reconsideration (p. 572).</i></p> <p><i>CMS Multi-Payer Models: CMS makes parallel proposals for CMS Multi-Payer Models (p. 578).</i></p> <p><i>Medicare Health Plans: CMS makes parallel proposals for Medicare Health Plans (p. 586).</i></p>
<p>CMS Notification (p. 564)</p>	<p><i>CMS will notify payers of determinations for each request as soon as practicable after the relevant Submission Deadline.</i></p> <p><i>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.</i></p> <p>The provisions similarly apply to states submitting information on Medicaid APMs and Medicaid Medical Home Models (p. 573), CMS Multi-Payer Models (p. 578), and Medicare Health Plans (p. 586).</p>
<p>CMS Posting of Other Payer Advanced APMs (p. 564)</p>	<p><i>Prior to the start of the relevant All-Payer QP Performance Period, CMS will 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.</i> 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.”</p> <p><i>CMS proposes to post, on a CMS website, only the following information about Other Payer arrangements that are determined to be Other Payer Advanced APMs (p. 602):</i></p> <ul style="list-style-type: none"> • 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. <p>CMS previously finalized that, to the extent permitted by Federal law, CMS would maintain confidentiality</p>

Payer Initiated Process Proposals	
	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. <i>CMS proposes 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. 602).</i>
Certification and Program Integrity (p. 599)	<p><i>CMS proposes to add a new 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. CMS also proposes that this certification must accompany the Payer Initiated Submission Form and any supporting documentation that payers submit to us through this process.</i></p> <p><i>CMS proposes to revise and clarify the monitoring and program integrity provisions:</i></p> <ul style="list-style-type: none"> • 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 must be maintained for 10 years after submission. • CMS proposes that such information and supporting documentation must be provided upon request. <p>CMS previously finalized that payers must attest to the accuracy of information submitted by eligible clinicians. CMS received comments in opposition to this requirement. <i>In response, CMS proposes to eliminate the requirement at that payers attest that the information submitted by eligible clinicians is accurate.</i> Instead, <i>CMS proposes that payers must certify only the information they submit directly to CMS (p. 600).</i></p>

APM Entity or Eligible Clinician Initiated Other Payer Advanced APM Determination Process (Eligible Clinician Initiated Process (p. 565)).

CMS previously finalized a policy that APM Entities and Eligible Clinicians in payment arrangements with Other Payers would be able to request determinations on whether an Other Payer arrangement is an Other Payer Advanced APM *after* the QP Performance Period (p. 565). ***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) (p. 566).*** This process would not be necessary for Other Payer arrangements that are determined to be Other Payer Advanced APMs under the Payer Initiated Process.

Eligible Clinician Initiated Process Proposals	
Guidance and Submission Form (p. 566)	<p>CMS will make <u>guidance</u> available regarding the Eligible Clinician Initiated Process for each payer type prior to the first Submission Period (2018).</p> <p><i>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.</i> 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> <p>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</p>

Eligible Clinician Initiated Process Proposals

	<p>Entities or eligible clinicians to attach supporting documentation. <i>CMS proposes that APM Entities or eligible clinicians may submit requests for review of multiple other payer arrangements through the Eligible Clinician Initiated Process.</i> CMS would 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. APM Entities or eligible clinicians may submit other payer arrangements with different tracks within that arrangement as one request along with information specific to each track.</p> <p><u>Medicaid</u>: 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. 574).</p> <p><u>CMS Multi-Payer Models</u>: CMS will make guidance available regarding the Eligible Clinician Initiated Process for other payer arrangements in CMS Multi-Payer Models prior to the first Submission Period (2019) (p. 579).</p> <p><u>Medicare Health Plans</u>: CMS will make guidance available regarding the Eligible Clinician Initiated Process for Medicare Health Plan payment arrangements prior to the first Submission Period (2019).</p> <p><u>Remaining Other Payers</u>: CMS will make guidance available regarding the Eligible Clinician Initiated Process for remaining other payer arrangements prior to the first Submission Period (2019) (p. 590).</p>
<p>Submission Form Content (p. 597)</p>	<p><i>CMS proposes to require that payers submit the following information for each other payer arrangement:</i></p> <ul style="list-style-type: none"> • Arrangement name; • Brief description of the nature of the arrangement; • Term of the arrangement (anticipated start and end dates); • Participant eligibility criteria²¹; • Locations (nationwide, state, or county) where this other payer arrangement will be available; • Evidence that the CEHRT criterion is satisfied²²; • Evidence that the quality measure criterion is satisfied (including an outcome measure²³); • 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). <p><i>CMS proposes that a submission for an Other Payer Advanced APM determination is complete only if <u>all</u> of these elements are submitted.</i></p> <p>APM Entities or Eligible Clinicians may also inform CMS that they are participating in an Other Payer arrangement that CMS determined to be an Other Payer Advanced APM for the year. <i>CMS proposes that an APM Entity or Eligible Clinician would indicate which Other Payer Advanced APMs they participated in during the All-Payer QP Performance Period (and include copies of participation agreements or similar contracts (or relevant portions of them) to document their participation in those payment</i></p>

²¹ In order to assess whether Medicaid APMs and Medicaid Medical Home Models are “available” for participation in order to calculate the QP threshold score denominators, CMS noted elsewhere in the rule that this would include requesting information about Medicaid APMs and Medicaid Medical Home Models and which specialties are eligible to participate ([p. 625](#)).

²² CMS believes that some Other Payer arrangements may only require CEHRT use at the individual Eligible Clinician level in a contract that the Eligible Clinicians has with the payer, and CMS is concerned that it might be challenging for Eligible Clinicians to submit information that would help CMS to determine whether at least 50 percent of Eligible Clinicians under the payment arrangement are required to use CEHRT to document and communicate clinical care. Therefore, ***CMS proposes 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. 603](#)).

²³ Additional information on the certification of whether an outcome measure is available can be found on [p. 602](#).

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	<p>arrangements.</p>
<p>Submission Period (p. 567)</p>	<p>CMS proposes 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. 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> <p><u>Medicaid</u>: CMS proposes that APM Entities or eligible clinicians may submit Eligible Clinician Initiated Forms for payment arrangements authorized under Title XIX beginning on September 1 of the calendar year prior to the All-Payer QP Performance Period. CMS proposes that the Submission Deadline is November 1 of the calendar year prior to the All-Payer QP Performance Period (p. 575).</p> <p><u>CMS Multi-Payer Models</u>: CMS proposes 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. 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. 580).</p> <p><u>Medicare Health Plans</u>: CMS propose 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. 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. 587).</p> <p><u>Remaining Other Payers</u>: CMS proposes 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. 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. 591).</p>
<p>CMS Determination (p. 567)</p>	<p>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 proposes 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 10 business days from the date informed. 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.</p> <p><u>Medicaid</u>: CMS makes parallel proposals for submissions related to Medicaid APMs and Medicaid Medical Home Models (p. 575).</p> <p><u>CMS Multi-Payer Models</u>: CMS makes parallel proposals for CMS Multi-Payer Models (p. 581).</p> <p><u>Medicare Health Plans</u>: CMS makes parallel proposals for Medicare Health Plans (p. 588).</p> <p><u>Remaining Other Payers</u>: CMS makes parallel proposals for Remaining Other Payers (p. 591).</p>
<p>CMS Notification (p. 567)</p>	<p>CMS proposes to 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> <p>CMS added that APM Entities and eligible clinicians who submit complete Eligible Clinician Initiated Submission Forms by September 1 of the calendar year of the relevant All-Payer QP Performance Period may allow for CMS to make Other Payer Advanced APM determinations and inform APM Entities or eligible clinicians of those determinations prior to the December 1 QP Determination Submission</p>

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	<p>Deadline. If CMS determines that an Other Payer arrangement is not an Other Payer Advanced APM notifying APM Entities or eligible clinicians of such a determination may help to avoid the burden of submitting payment amount and patient count information for that payment arrangement. CMS intends to make these early notifications to the extent possible.</p> <p><i>CMS proposes 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 have determined that the other payer arrangement is not an Other Payer Advanced APM for a prior year.</i></p> <p><u>Medicaid</u>: CMS makes parallel proposals for submissions related to Medicaid APMs and Medicaid Medical Home Models (p. 575).</p> <p><u>CMS Multi-Payer Models</u>: CMS makes parallel proposals for CMS Multi-Payer Models (p. 581).</p> <p><u>Medicare Health Plans</u>: CMS makes parallel proposals for Medicare Health Plans (p. 588).</p> <p><u>Remaining Other Payers</u>: CMS makes parallel proposals for Remaining Other Payers (p. 591).</p>
<p>CMS Posting of Other Payer Advanced APMs (p. 568)</p>	<p><i>CMS proposes to 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.</i> 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> <p><u>Medicaid</u>: CMS makes parallel proposals for submissions related to Medicaid APMs and Medicaid Medical Home Models (p. 576).</p> <p><u>CMS Multi-Payer Models</u>: CMS makes parallel proposals for CMS Multi-Payer Models (p. 582).</p> <p><u>Medicare Health Plans</u>: CMS makes parallel proposals for Medicare Health Plans (p. 588).</p> <p><u>Remaining Other Payers</u>: CMS makes parallel proposals for Remaining Other Payers (p. 592).</p> <p><i>Prior to the start of the relevant All-Payer QP Performance Period, CMS will 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.</i> 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.”</p> <p><i>CMS proposes to post, on a CMS website, only the following information about Other Payer arrangements that are determined to be Other Payer Advanced APMs</i> (p. 602):</p> <ul style="list-style-type: none"> • 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. <p>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. <i>CMS proposes that, with the exception of the specific information proposed for posting above, the information an APM Entity or eligible clinician submits through the Eligible Clinician 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</i> (p. 602).</p>
<p>Certification & Program</p>	<p>CMS previously finalized that payers must attest to the accuracy of information submitted by eligible clinicians. CMS received comments in opposition to this requirement. <i>In response, CMS proposes to</i></p>

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Integrity (p. 600)

eliminate the requirement at that payers attest that the information submitted by eligible clinicians is accurate. Instead, ***CMS proposes that payers must certify only the information they submit directly to CMS.***

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 proposes removing this requirement as previously finalized and proposes 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.***

In the case of information submitted by an APM Entity, ***CMS proposes that the certification be made by a person with the authority to bind the APM Entity. CMS proposes that this certification accompany the Eligible Clinician Initiated Submission Form and any supporting documentation that eligible clinicians submit.*** Under current regulation, APM Entities or eligible clinicians may be subject to audit of the information and supporting documentation provided under the certification. CMS proposes to clarify the nature of the information subject to the record retention requirements: ***CMS proposes 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.***

A timeline for Other Payer Advanced APM determinations by payer type is available in [Table 54](#). ***CMS also seeks comment on ways to reduce burden in the submission requirements on states, payers, APM Entities, and Eligible Clinicians while still allowing for CMS receipt of necessary information to make Other Payer Advanced APM determinations*** (p. 599).

Medicaid APMs and Medicaid Medical Home Models (p. 568)

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*²⁴ (p. 569). 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 (p. 570).

- ***Medicaid & the Payer Initiated Process: CMS proposes that any states (or territories) may request a determination prior to the All-Payer QP Performance Period whether Other Payer arrangements authorized under Title XIX are Medicaid APMs or Medicaid Medical Home Models that meet the Other***

²⁴ CMS clarified that payment arrangements offered by Medicare-Medicaid Plans operating under the Financial Alignment Initiative for Medicare-Medicaid Enrollees will not be considered either a “Medicaid APM” or a “Medicaid Medical Home Model, and therefore, the presence of such an arrangement alone will not preclude the exclusion of Title XIX (Medicaid) payments and patients in the All-Payer Combination Option (p. 625).

Payer Advanced APM criteria (p. 570). This includes both Medicaid fee-for-service and Medicaid managed care plan payment arrangements.²⁵

- **Medicaid & the Eligible Clinician Initiated Process:** CMS believes it is not feasible to allow APM Entities and eligible clinicians to request determinations for the Title XIX (Medicaid) payment arrangements after the conclusion of the All-Payer QP Performance Period (p. 573). Therefore, **CMS proposes to require that APM Entities and Eligible Clinicians seeking determinations on Medicaid payment arrangements must do so at “an earlier point, prior to the All-Payer Performance Period”** (p. 574).

CMS summarizes the timeline for submissions (under both the Payer Initiated and Eligible Clinician Initiated Processes) in [Table 50](#).

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** (p. 623). 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 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 county where the Eligible Clinician saw the most patients during the relevant All-Payer QP Performance Period was a county where a Medicaid APM or Medicaid Medical Home Model determined to be an Other Payer Advanced APM was available** (p. 624). **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 also notes that in cases where participation in a model is limited to Eligible Clinicians in certain specialties, CMS does not believe the Medicaid APM or Medicaid Medical Home Model is effectively “available” to Eligible Clinicians who are not in those specialties. Therefore, **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** (p. 625).

CMS Multi-Payer Models (p. 576)

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 (p. 577).²⁶ **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 intends to make separate determinations about each of those other payer arrangements in a CMS Multi-Payer Model on an individual basis (i.e. Other Payer arrangements aligned with an Advanced APM in a CMS Multi-Payer Model is not automatically an Other Payer Advanced APM by virtue of its alignment). **CMS proposes that if the payment arrangement in the CMS Multi-Payer arrangement is a payment arrangement authorized under Title XIX (Medicaid) that the rely on the processes laid out for Medicaid arrangements (discussed above).**

CMS also notes that some CMS Multi-Payer Models involve an agreement with a state to test an APM in a state where the state prescribes uniform payment arrangements across state-based payers. CMS believes it may be appropriate for states (rather than any Other Payer) to submit determination requests and information for these payment 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**

²⁵ CMS proposes to only accept the determination requests from the state (not the Medicaid managed care plans themselves) given that “states are responsible ultimately for the administration of their Medicaid programs.” (p. 570).

²⁶ Examples include the Comprehensive Primary Care Plus (CPC+) Model, the Oncology Care Model (OCM) (2-sided risk arrangement), and the Vermont All-Payer ACO Model (p. 577).

rules for CMS Multi-Payer Models would apply ([p. 582](#)).

CMS summarizes the timeline for submissions related to CMS Multi-Payer Models (under both the Payer Initiated and Eligible Clinician Initiated Models) in [Table 51](#).

Medicare Health Plans ([p. 583](#))

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*** ([p. 583](#)).

- ***Medicare Health Plans & the Payer Initiated Process: 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 and coverage year*** ([p. 584](#)).
- ***Medicare Health Plans & the Eligible Clinician Initiated Process: CMS makes proposals similar to what it proposes for other payer types*** ([p. 586](#)).

CMS summarizes the timeline for submissions related to Medicare Health Plans (under both the Payer Initiated and Eligible Clinician Initiated Models) in [Table 52](#).

Remaining Other Payers ([p. 589](#))

- ***Remaining Other Payers & the Payer Initiated Process: 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*** ([p. 589](#)).
- ***Remaining Other Payers & the Eligible Clinician Initiated Process: 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 with the 2019 All-Payer QP Performance Period*** ([p. 590](#)).

CMS summarizes the timeline for submissions for Remaining Other Payers under Eligible Clinician Initiated Process in [Table 53](#).

Calculation of All-Payer Combination Option Threshold Scores and QP Determinations ([p. 611](#))

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).
- **Payment Amount and Patient Counts.** CMS finalized the annual All-Payer Combination Option QP payment amount and patient count thresholds which are reviewed in [Table 46](#) and [Table 47](#), beginning with Payment Year 2021.
- **Exclusions.** In order to calculate the denominator for QP determinations under the All-Payer Combination Option, CMS previously finalized excluded payments as specified in the statute and excluded patients associated with these excluded payments from the patient count method. These collectively include payments:
 - By the Secretary of Defense for the costs of Department of Defense health care programs;
 - By the Secretary of Veterans Affairs for the costs of Department of Veterans Affairs health care programs; and

- Under Title XIX in a state in which no Medicaid Medical Home Model or APM is available under the state plan. (As required by statute and discussed above, regarding Title XIX (Medicaid) payments, CMS finalized that Title XIX payments or patients would be excluded in the numerator and denominator for the QP determination unless: (1) a state has at least one Medicaid Medical Home Model or Medicaid APM in operation that is determined to be an Other Payer Advanced APM; and (2) the relevant Advanced APM Entity is eligible to participate in at least one of such Other Payer Advanced APMs during the QP Performance Period, regardless of whether the Advanced APM Entity actually participates in such Other Payer Advanced APMs (for both the payment amount and patient count methods).

Timing of QP Determinations Under the All-Payer Combination Option (p. 613)

CMS previously finalized that the QP Performance Period for both the Medicare Option and the All-Payer Combination Option would begin on January 1 and end on August 31 of the calendar year that is two years prior to the payment year. ***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 (p. 613).*** The timeline for the Medicare Option will remain the same.

- Under this timeline, ***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 (p. 616).***
- In addition, ***CMS proposes that an Eligible Clinician must meet the relevant QP or Partial QP threshold in the same timeframe and using the same data.*** That is, CMS would not assess an Eligible Clinician under the All-Payer Combination Option using their Advanced APM payment amount (or patient count) information from January 1 through March 31 and their Other Payer Advanced APM payment amount (or patient count) information from January 1 through June 30 (p. 616).
- ***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 (p. 616).***

CMS also proposes an alternative: ***whether to establish the All-Payer QP Performance Period from January 1 through March 31 of the calendar year that is 2 years prior to the payment year*** to provide more time for Eligible Clinicians to submit information to enable a QP determination under the All-Payer combination option (p. 614). CMS previously finalized a “snapshot” approach that would allow an Eligible Clinician to attain QP status based on Advanced APM participation from January 1 through March 31.

If CMS does not adopt either approach, it will retain the previously finalized All-Payer QP Performance Period (January 1 – August 31) (p. 615).

QP Determinations Under the All-Payer Combination Option (p. 617)

QP Determinations at the Individual Eligible Clinician Level. CMS previously finalized a policy where it would calculate the threshold scores used to make QP determinations under the All-Payer Combination Option (unless certain exceptions apply). Based on further consideration, ***CMS proposes to make QP determinations under the All-Payer Combination at the individual Eligible Clinician level only (p. 617).*** CMS makes this change because it believes that Eligible Clinicians in an APM Entity group used for determining thresholds under the Medicare option, would, under the All-Payer Combination Option, have little, if any common group-level participation in Other Payer Advanced APMs and therefore not have agreed to share risks and rewards for Other Payer Advanced APM participation. ***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 (p. 618).***

CMS notes that if it were to make QP determinations at the group level, it envisions significant challenges in obtaining information necessary at the APM Entity group level under the All-Payer Combination option. ***CMS***

requests input on whether APM Entities in Other Payer Advanced APMs could report this information at the APM Entity Group level to facilitate CMS QP determinations at the group level (p. 619).

Affiliated Practitioner List Exception. 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 (p. 619).***

Use of Individual or APM Entity Group Information for Medicare Payment Amounts and Patient Count

Calculations. Because CMS proposes to make QP determinations at the individual Eligible Clinician level under the All-Payer Combination Option, ***CMS proposes to use individual Eligible Clinician-level payment amounts and patient counts for the Medicare calculations in the All-Payer Combination Option (p. 620).*** 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:***

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

CMS provides an example beginning in [Table 55](#) and following on [p. 622](#).

Payment Amount Method

CMS previously finalized the following for purposes of making the QP determinations under the All-Payer Combination Option:

- **Numerator:** the aggregate of all payments from all other payers (except those excluded) to the APM Entity's eligible clinicians—or the eligible clinician in the event of an individual eligible clinician assessment—under the terms of all Other Payer Advanced APMs during the QP Performance Period.
- **Denominator:** the aggregate of all payments from all other payers (except those excluded) to the APM Entity's eligible clinicians—or the eligible clinician in the event of an individual eligible clinician assessment—during the QP Performance Period.

CMS finalized that it will calculate the threshold score by dividing the numerator value by the denominator value. CMS will compare that threshold score to the finalized QP Payment Amount Threshold and the Partial QP Payment Amount Threshold and determine the QP status of the Eligible Clinicians for the payment year.

CMS proposes several modifications to its policies.

- To implement its proposal to make QP determinations under the All-Payer Combination Option only at the Eligible Clinician level, ***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 March 31 or January 1 through June 30 of the All-Payer QP Performance Period (p. 627).***
- In addition, ***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 (p. 627).***

Patient Count Method

CMS previously finalized the following for purposes of making the QP determinations under the All-Payer

Combination Option

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

CMS finalized that it would count each unique patient one time in the numerator and one time in the denominator.

CMS proposes modifications to its policies:

- To implement its proposal to make QP determinations under the All-Payer Combination Option only at the Eligible Clinician level, ***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*** ([p. 628](#)).
- ***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 31 or January 1 through June 30 of the All-Payer Combination Option*** ([p. 628](#)).

Submission of Information for QP Determinations

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

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

CMS is making several proposals related to these provisions:

- **Required Information.** CMS clarified that an Eligible Clinician does not need to submit Medicare payment or patient information for QP determinations under the All-Payer Combination Option ([p. 629](#)).
 - ***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)*** ([p. 630](#)). CMS seeks comment on the feasibility of submitting information this way and suggestions on how to reduce the reporting burden.
 - Alternatively, if CMS finalizes an All-Payer Performance Period of January 1 – March 31, CMS would only need information for January 1 – March 31.
 - If CMS retains the current finalized QP Performance Period, CMS would need information aggregated for three snapshot timeframe (January 1 – March 31; January 1 – June 30; and January 1 – August 31).
 - In alignment with other proposals, ***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)*** ([p. 630](#)).

- **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 (p. 630).**
- **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 (p. 630).**
- **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 (p. 631).**
- **QP Determination 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 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”) (p. 631).**
- **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 (p. 632).** When submitted on behalf of an APM Entity, certification must be made by someone with the authority to legally bind the APM Entity. The certification would accompany the Eligible Clinician Initiated Submission Form.
 - CMS previously finalized that an APM Entity or eligible clinician that submits information for assessment under the All-Payer Combination Option must maintain such books contracts records, documents, and other evidence for a period of 10 years from the final date of the QP Performance Period or from the date of completion of any audit, evaluation, or inspection, whichever is later. CMS also finalized that Eligible Clinicians and APM Entities must maintain copies of any supporting documentation related to the All-Payer Combination Option for at least 10 years. **CMS proposes to revise the policy to apply to information submitted to**
 - **for QP determinations (p. 632).** **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 (p. 633).**
- **Use of Information.** CMS previously finalized that, to the extent permitted by federal law, CMS will maintain confidentiality of the information and data that APM Entities and Eligible Clinicians submit to support Other Payer Advanced APM determinations in order to avoid dissemination of potentially sensitive contractual information or trade secrets. **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 (p. 633).**

CMS provides an example of a QP determination for an Eligible Clinician in an Advanced APM Medicare ACO Model, a commercial ACO arrangement, and a Medicaid APM beginning on [p. 633](#) and in [Table 56](#) and [Table 57](#).

Partial QP Election to Report to MIPS (p. 636)

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 (p. 637).**

Physician-Focused Payment Models (PFPMs) (p. 642)

CMS previously finalized its definition of a PFPM to be “An APM: (1) in which Medicare is a payer; (2) in which eligible clinicians that are eligible professionals as defined in section 1848(k)(3)(B) of the Act are participants and play a core role in implementing the APM’s payment methodology, and (3) which targets the quality and costs of services that eligible clinicians participating in the Alternative Payment Model provider, order, or can significantly influence.” CMS included that PFPMs could be payers in addition to Medicare, but PFPM proposals would need to include Medicare as a payer. ***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*** (p. 643).

In addition:

- ***CMS seeks input on the impact of broadening the definition further given that the Secretary does not have the authority to direct the design or development of payment arrangements that might be tested with private payers*** (p. 644).
- ***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 also highlighted that the finalized definition of a PFPM includes that the model be “an APM,” which is defined by MACRA as: (1) A model under section 1115A of the Act (other than a health care innovation award); (2) the Shared Savings Program under section 1899 of the Act; (3) a demonstration under section 1866C of the Act; or (4) a demonstration required by federal law. CMS notes, however, that a payment arrangement with Medicaid or CHIP as the payer (but not Medicare) would not necessarily meet the definition of an APM. ***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.”*** (p. 645). More information about CMS’ authority rationale can be found on p. 645. ***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 did note that it believes that PFPMs must continue to include innovative payment methodologies and not be arrangements focused on care delivery reform without a payment reform component.

Relationship between PFPMs and Advanced APMs (p. 646)

CMS reiterated its finalized policy that PFPMs need not meet the requirements to be an Advanced APM. However, if CMS was to broaden the definition of a PFPM to include payment arrangements with Medicaid or CHIP (but not Medicare) as a payer, stakeholders could propose PFPMs that were Medicaid APMs, Medicaid Medical Home Models or Other Payer arrangements involving Medicaid and CHIP as a payer.

CMS notes that it “intends to give serious consideration to proposed PFPMs recommended by the PTAC.” (p. 646). 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 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.***

PFPM Criteria (p. 648)

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 PFFM proposal.

[Collection of Information Requirements \(p. 650\)](#)

In the 2017 QPP final rule, CMS estimated a reduction in burden hours of 1,066,658 and reduction of burden costs of \$7.4 million relative to the legacy programs it replaced (81 FR 77513). The total existing burden for the previously approved information collections related to the 2017 final rule was approximately 11 million hours and a total labor cost of reporting of \$1.311 million. ***CMS estimates that the policies proposed in this rule would result in further reduction of 132,620 burden hours and a further reduction in burden cost of \$12.4 million relative to a baseline of continuing the policies in the 2017 QPP final rule.*** The year 2 reduction in burden reflects several proposed policies, including significant hardships or other types of exceptions, including a new significant hardship exception for small practices for the ACI performance category; a shorter version of the CAHPS for MIPS survey; allowing election of facility-based measurement for applicable MIPS eligible clinicians, thereby eliminating the need for additional quality data submission processes; and allowing MIPS eligible clinicians to form virtual groups which would create efficiencies in data submission. CMS also anticipates further reduction in burden as a result of greater clinician familiarity with the measures and data submission methods set in their second year of participation, operational improvements streamlining registration and data submission, and continued growth in the number of QPs that are excluded from MIPS. This expected growth is due in part to reopening of CPC+ and Next Generation ACO for 2018, and the ACO Track 1+ which is projected to have a large number of participants, with a large majority reaching QP status. ***CMS estimates that there will be between 180,000 and 245,000 eligible clinicians that will become QPs for the 2018 performance period compared to 110,159 eligible clinicians that are estimated to become QPs during the 2017 performance period, an increase of between 69,841 and 134,841.***

[Wage Estimates \(p. 654\)](#)

[Table 58](#) presents the adjusted hourly wages used in burden estimates.

[Framework for Understanding the Burden of MIPS Data Submission \(p. 655\)](#)

[Table 59](#) presents a framework for understanding how the organizations permitted or required to submit data on behalf of clinicians varies across the types of data, and whether the clinician is a MIPS eligible clinician, MIPS APM participant, or an Advanced APM participant.

[Burden for Virtual Group Election \(p. 658\)](#)

CMS assumes that virtual group participation will be relatively low in the first year because stakeholders seem to need at least 3-6 months to form groups and establish agreements before signing up. CMS is not able to give them that much time in the first year, rather closer to 60 days.

[Table 60](#) summarizes estimated burden for virtual group election process. CMS estimates that approximately 765 MIPS eligible clinicians will decide to join 16 virtual groups for the 2018 MIPS performance period and will report via registry.

[Burden for Election of Facility-Based Measurement \(p. 662\)](#)

[Table 61](#) estimates participation in facility-based measurement, based on 2015 data from the PQRS and the first 2019 MIPS payment year. CMS estimates 18,207 respondents (17,943 MIPS eligible clinicians who practice primarily in the hospital electing as individuals and 264 groups with 75% or more of their clinicians qualifying as clinicians who practice primarily in hospital) will elect facility-based measurement in the 2018 MIPS performance period.

[Table 62](#) summarizes the estimated burden for election to participate in facility-level measurement.

[Burden for Third Party Reporting \(p. 665\)](#)

[Table 63](#) summarizes the estimated burden for QCDR and registry self-nomination.

Burden Estimates for the Quality Performance Category (p. 669)

Table 65 provides estimated counts of clinicians that will submit quality performance category data as MIPS individual clinicians, groups, or virtual groups in the 2018.

- 364,002 clinicians will submit as individuals via claims submission mechanisms;
- 225,569 clinicians will submit as individuals, or as part of groups or virtual groups via qualified registry or QCDR submission mechanisms;
- 115,241 clinicians will submit as individuals, or as part of groups or virtual groups via EHR submission mechanisms; and
- 101,939 clinicians will submit as part of groups via the CMS Web Interface.

These estimated numbers account for the proposed policy that individual clinicians, groups, and virtual groups can be scored on data submitted via multiple submission mechanisms. Hence, the estimated numbers of individual clinicians, groups, and virtual groups to submit via the various submission mechanisms are not mutually exclusive, and reflect the occurrence of individual clinicians or groups that submitted data via multiple mechanism under the 2015 PQRS.

Table 66 shows the estimated number of clinicians submitting quality performance data as individuals.

- 364,002 clinicians will submit as individuals via claims submission mechanisms;
- 86,046 clinicians will submit as individuals via qualified registry or QCDR submission mechanisms; and
- 60,253 clinicians will submit as individuals via EHR submission mechanisms.

Again, consistent with the proposed policy to allow individual clinicians to be scored on quality measures submitted via multiple mechanisms, the columns in Table 66 are not mutually exclusive.

Table 67 provides the estimated number of groups and virtual groups submitting quality performance data by mechanism on behalf of clinicians.

- 2,455 groups and virtual groups will submit data via QCDR/registry submission mechanisms on behalf of 146,676 clinicians;
- 817 groups and virtual groups will submit via EHR submission mechanisms on behalf of 56,772 eligible clinicians; and
- 298 groups will submit data via the CMS Web Interface on behalf of 102,914 clinicians.

Table 68 includes a burden estimate for the quality category for clinicians using the claims submission mechanism. Based on experience with the PQRS, CMS estimates that the burden for submission of quality data will range from 0.22 hours to 10.8 hours per clinician. The wide range of estimates for the time required for a clinician to submit quality measures via claims reflects the wide variation in complexity of submission across different clinician quality measures. CMS also estimates that the cost of quality data submission using claims will range from \$19.38 to \$951.48.

Table 69 includes the burden estimate for the quality category for clinicians (participating individually or as part of a group or virtual group) using the qualified registry/QCDR submission. CMS estimates 9.083 burden hours per respondent and total estimated annual costs per respondent to be approximately \$851.05.

Table 70 includes the burden estimate for the quality category for clinicians using the EHR mechanism. CMS estimates 10 total burden hours per respondent and the total estimated annual cost per respondent to be \$932.14.

Table 71 includes burden estimate related to quality data submission via the CMS Web Interface.

Table 72 includes burden estimates for beneficiary participation in the CAHPS for MIPS Survey.

[Burden Estimates for Advancing Care Information Data \(p. 692\)](#)

[Table 75](#) includes burden estimates for the application for ACI reweighting.

[Table 76](#) includes the estimated number of respondents to submit ACI data on behalf of clinicians.

[Table 77](#) includes the estimated burden the ACI data submission. CMS estimates it would take 3 hours per respondent at a cost of \$264.30/hour.

[Burden Estimates for Improvement Activities Submission \(p. 698\)](#)

[Table 78](#) includes estimated numbers of organizations submitting Improvement Activities data on behalf of clinicians.

- 520,654 clinicians will submit improvement activities as individuals during the 2018 MIPS performance period;
- 3,818 groups to submit improvement activities on behalf of clinicians during the 2018 MIPS performance period; and
- 16 virtual groups to submit improvement activities

[Table 79](#) includes the estimated burden for Improvement Activities submission. CMS estimates that approximately 524,488 respondents will be submitting data under the Improvement Activities performance category, each spending 2 hours at a cost of \$88.10/hour.

[Estimated Burden for Cost Category \(p. 700\)](#)

CMS does not anticipate any new or additional submission requirements for MIPS eligible clinicians under this category.

[Burden Estimates Regarding Partial QP Elections \(p. 701\)](#)

[Table 81](#) includes the estimated burden for partial QP election. CMS assumes that 17 APM Entities will make the election to participate as a partial QP in MIPS, costing \$22.03.

[Burden Estimates for Other Payer Advanced APM Identification: Payer-Initiated Process \(p. 702\)](#)

[Table 82](#) includes the burden for prospective identification of other payer advanced APMs. CMS estimates that 300 other payer arrangements will be submitted (50 Medicaid payers, 150 MA Organizations, and 100 Multi-payers) for identification as Other Payer Advanced APMs, which would take 10 hours per payment arrangement at a cost of \$881.00.

[Summary of Annual Burden Estimates \(p. 704\)](#)

[Table 84](#) includes an estimate of the burden of the proposed annual recordkeeping and submission requirements. CMS estimates this at 9,391,175 hours with total labor cost of \$856,996,819. CMS estimates that the proposed rule will reduce burden by 132,620 hours and \$12,372,275 in labor costs relative to the estimated baseline of continued transition year policies.

Regulatory Impact Analysis (p. 709)

[Statement of Need \(p. 709\)](#)

According to CMS, this proposed rule is necessary to make statutorily required policy changes and other policy updates to MIPS as well as the policies related to the Advanced APM provisions of MACRA.

This proposed rule for QPP Year 2 reflects this feedback and includes several proposals that extend transition year policies finalized in the 2017 QPP final rule with comment period; however, CMS also includes policies to

begin ramping up to full implementation, since the performance threshold must be based on the mean or median of prior year performance under statute starting in the 2019 MIPS performance period. Additionally, CMS addresses elements of MACRA that were not included in the first year of the program, including virtual groups, facility-based measurement, and improvement scoring. CMS also includes proposals to continue implementing elements of MACRA that do not take effect in the first or second year of the QPP, including policies related to the All-Payer Combination Option for the APM incentive.

Overall Impact (p. 710)

CMS examined the impact of this proposed rule as required by numerous Executive Orders and statutes, as outlined in the table below.

Executive Order/Statute	Requirement	Agency Analysis
<p>Executive Order 12866 on Regulatory Planning and Review (September 30, 1993)</p> <p>Executive Order 13563 on Improving Regulation and Regulatory Review (February 2, 2013)</p> <p>Congressional Review Act (5 U.S.C. 804(2))</p>	<p>Direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year).</p>	<p>CMS estimates that the Medicare Part B provisions included in this proposed rule will redistribute more than \$173 million in budget neutral payments in the second performance year. In addition, this proposed rule will increase government outlays for the exceptional performance payment adjustments under MIPS (\$500 million), and incentive payments to QPs (approximately \$590-\$800 million). Overall, this rule will transfer more than \$1 billion in payment adjustments for MIPS eligible clinicians and incentive payments to QPs. Therefore, this rulemaking is “economically significant” as measured by the \$100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, CMS prepared a RIA that, to the best of CMS’ ability, presents the costs and benefits of the rulemaking.</p>
<p>Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017)</p>	<p>Requires that any incremental costs associated with a new regulatory action shall be offset by the elimination of existing costs associated with at least two prior regulations.</p>	<p>This proposed rule would reduce the information collection requirements (ICR) burden by 132,620 hours and would result in a further reduction in burden costs of \$12.4 million in the QPP Year 2 relative to QPP Year 1. CMS estimates that total regulatory review costs associated with the QPP would be approximately \$4.8 million.</p>
<p>Regulatory Flexibility Act (Pub. L. 96-354 enacted September 19, 1980) (RFA)</p>	<p>Requires agencies to prepare an Initial Regulatory Flexibility Analysis to describe and analyze the impact of the final rule on small entities unless the Secretary can certify that the regulation will not have a significant impact on a substantial number of small entities. The RFA requires agencies to analyze options for regulatory relief of small entities.</p> <p>Note that Small Business Administration (SBA) standards for small entities differ than the definition of a small practice in MIPS under §414.1305. The SBA standard for a small business is \$11 million in average receipts for an office of clinicians and \$7.5 million in average</p>	<p>Approximately 95% of practitioners, other providers, and suppliers are considered to be small entities either by nonprofit status or by having annual revenues that qualify for small business status under the SBA standards. There are over 1 million physicians, other practitioners, and medical suppliers that receive Medicare payment under the PFS. Because many of the affected entities are small entities, the analysis and discussion provided in this Regulatory Impact Analysis section as well as elsewhere in this proposed rule is intended to comply with the requirement for an Initial Regulatory Flexibility Analysis</p>

	annual receipts for an office of other health practitioners.	
Section 1102(b) of the Act	Requires CMS to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small hospitals located in rural areas. This analysis must conform to the provisions of section 603 of the RFA.	For purposes of section 1102(b) of the Act, CMS defines a small hospital located in a rural area as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. CMS did not prepare an analysis for section 1102(b) of the Act because it determined, and the Secretary certifies, that this proposed rule would not have a significant impact on the operations of a substantial number of small hospitals located in rural areas.
Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4 enacted March 22, 1995)	Requires that agencies assess anticipated costs and benefits on state, local, or tribal governments or on the private sector before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2017, that threshold is approximately \$148 million.	This proposed rule would impose no mandates on state, local, or tribal governments or on the private sector because participation in Medicare is voluntary and because physicians and other clinicians have multiple options as to how they will participate under MIPS and discretion over their performance. Moreover, HHS interprets UMRA as applying only to unfunded mandates. CMS does not interpret Medicare payment rules as being unfunded mandates, but simply as conditions for the receipt of payments from the federal government for providing services that meet federal standards. This interpretation applies whether the facilities or providers are private, state, local, or tribal.
Executive Order 13132 on Federalism (August 4, 1999)	Establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct effects on state and local governments, preempts state law, or otherwise has Federalism implications.	CMS outlined in this proposed rule a payer-initiated identification process for identifying which payment arrangements qualify as Other Payer Advanced APMs. State Medicaid programs may elect to participate in the payer-initiated identification process. CMS does not believe any of these policies impose a substantial direct effect on the Medicaid program as participation in the Payer Initiated Determination Process is voluntary and use of the Eligible Clinician Initiated Determination Process is also voluntary.

Changes in Medicare Payments ([p. 715](#))

The largest component of the MACRA costs is its replacement of scheduled reductions in physician payments with payment rates first frozen at 2015 levels and then increasing at a rate of 0.5% a year during CYs 2016 through 2019. The estimates in this RIA take those legislated rates as the baseline for the estimates CMS makes as to the costs, benefits, and transfer effects of this proposed regulation, with some proposed data submission provisions for the 2018 MIPS performance period taking effect in 2018 and 2019, and the corresponding positive and negative payment adjustments taking effect in the 2020 MIPS payment year.

Estimated Incentive Payments to QPs in Advanced APMs ([p. 715](#))

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.

Estimated Numbers of Clinicians Eligible for MIPS ([p. 718](#))

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.

Estimated Impacts on Payments to MIPS Eligible Clinicians (p. 720)

Payment impacts in this proposed rule reflect averages by specialty and practice size based on Medicare utilization. The payment impact for a MIPS eligible clinician could vary from the average and would depend on the mix of services that the MIPS eligible clinician furnishes. The average percentage change in total revenues would be less than the impact displayed in CMS' tables because MIPS eligible clinicians generally furnish services to both Medicare and non-Medicare patients. In addition, MIPS eligible clinicians may receive substantial Medicare revenues for services under other Medicare payment systems that would not be affected by MIPS payment adjustment factors.

CMS uses a variety of data sources to estimate impacts on payments, including data from predecessor programs, the current MIPS program and Advanced APMs and various assumptions.

With the extensive changes to policy and the flexibility that is allowed under MIPS, estimating impacts of this proposed rule using only historic 2015 participation assumptions would significantly overestimate the impact on clinicians, particularly on clinicians in practices with 1-15 clinicians, which have traditionally had lower participation rates. To assess the sensitivity of the impact to the participation rate, CMS prepared two sets of analyses.

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 data²⁷. [Table 86](#) summarizes the impact on Part B services of MIPS eligible clinicians by specialty for the standard participation assumptions.

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

²⁷ PQRS participation rates have increased steadily since the program began; the 2015 PQRS Experience Report showed an increase in the participation rate from 15 percent in 2007 to 69 percent in 2015. In 2015, among those eligible for MIPS, 88.7 percent participated in the PQRS. In 2015, MIPS eligible practices of less than 1-15 clinicians participated in the PQRS at a rate of 69.7 percent. Because practices of 16-24 have a 91.7 percent participation rate based on historical data, and 25-99 clinicians have a 96.2 percent participation rate and practices of 100+ clinicians have a 99.4 percent participation rate, CMS assumed the average participation rates of those categories of clinicians would be the same as under the 2015 PQRS.

94.3% of MIPS eligible clinicians are expected to receive positive or neutral payment adjustments.

Potential Costs of Advancing Care Information and Improvement Activities for Eligible Clinicians (p. 741)

MIPS eligible clinicians who did not participate in the Medicare and Medicaid EHR Incentive Programs could potentially face additional operational expenses for implementation and compliance with the ACI performance category requirements, where those who already adopted an EHR during Stage 1 and 2 of the Medicare or Medicaid EHR Incentive Programs will have limited additional operational expenses related to compliance with the ACI performance category requirements. For some MIPS eligible clinicians, the ACI performance category will be weighted at 0% of the final score.

As it has stated with respect to the Medicare EHR Incentive Program, CMS believes future retrospective studies on the costs to implement an EHR and the return on investment (ROI) will demonstrate efficiency improvements that offset the actual costs incurred by MIPS eligible clinicians participating in MIPS and specifically in the ACI performance category, but CMS is unable to quantify those costs and benefits at this time. At present, evidence on EHR benefits in either improving quality of care or reducing health care costs is mixed. The adoption of EHR as a fully functioning part of medical practice is progressing, with numerous areas of adoption, use, and sophistication demonstrating need for improvement. Moreover, many of the most important benefits of EHR depend on interoperability among systems and this functionality is still lacking in many EHR systems.

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.

Similarly, the costs for implementation and complying with the improvement activities performance category requirements could potentially lead to higher expenses for MIPS eligible clinicians. However, given the lack of comprehensive historical data for improvement activities, CMS is unable to quantify those costs in detail at this time. ***CMS requests comments that provide information that would enable the agency to quantify the costs, costs savings, and benefits associated implementation of improvement activities.***

Impact on Beneficiaries (p. 744)

CMS maintains that changes resulting from this proposed rule may have a positive impact and improve the quality and value of care provided to Medicare beneficiaries. Broadly, CMS expects that clinician engagement in the QPP over time may result in improved quality of patient care, resulting in lower morbidity and mortality. The policies finalized in the 2017 QPP final rule, as well as policies in this rule, should lead to additional growth in the participation of both MIPS APMS and Advanced APMS, both of which promote care coordination and transformation.

Also, several Advanced APMS and MIPS APMS, such as Accountable Care Organizations (ACOs), have shown evidence of improving the quality of care provided to beneficiaries and beneficiaries' experience of care.

Impact on Other Health Care Programs and Providers (p. 750)

CMS estimates that the QPP Year 2 will not have a significant economic effect on eligible clinicians and groups.

CMS proposes several policies for the QPP Year 2 to reduce burden on clinicians. The flexibility to use EHR technology certified to either the 2014 Edition or the 2015 Edition for the QPP Year 2 is beneficial for vendors as it gives them additional time to deploy the updated software to their customers, which are the clinicians and other providers.

The proposed policy changes are reflected in the RIA estimates, which show that the risk for negative MIPS payment adjustment is minimal for MIPS eligible clinicians, including small and solo practices that meet the proposed data completeness requirements.

[Alternatives Considered \(p. 751\)](#)

CMS views the performance threshold as one of the most important factors affecting the distribution of payment adjustments under the Program, and the alternatives that it considered focus on that policy.

Under the 6-point performance threshold alternative, CMS estimated it would make approximately \$663.5 million in positive payment adjustments (including \$500 million in exceptional performance payments), and conversely, would make approximately \$163.5 million in negative payment adjustments. These results represent a roughly \$10 million reduction in the aggregate positive adjustments and a roughly \$10 million reduction in aggregate negative payment adjustments compared to the results displayed above in Table 86. Under the 6-point performance threshold, CMS also estimated that slightly fewer eligible clinicians would receive negative payment adjustments than in the 15-point model described above – approximately 3.1% in this alternative compared to approximately 3.9% in the 15-point model.

Under the 33-point performance threshold alternative, CMS estimated it would make approximately \$743.7 million in positive payment adjustments (including \$500 million in exceptional performance payments), and conversely, would make approximately \$243.7 million in negative payment adjustments. These results represent a roughly \$70 million increase in aggregate positive payment adjustments and a roughly \$70 million increase in aggregate negative payment adjustments compared to the results displayed above in [Table 86](#). Additionally, under the 33-point performance threshold alternative, CMS estimated that approximately 9.1% of eligible clinicians would receive a negative payment adjustment, compared to the approximately 3.9% that it estimated in the 15-point model.

[Assumptions and Limitations \(p. 752\)](#)

CMS reiterates earlier noted limitations, and also points out that its scoring model cannot fully reflect MIPS eligible clinicians' behavioral responses to MIPS and instead uses assumptions. Other potential behavioral responses are not addressed in the scoring model. Also, the scoring model does not reflect the growth in Advanced APM participation between 2017 and 2018. Finally, to the extent that there are year-to-year changes in the data submission, volume and mix of services provided by MIPS eligible clinicians, the actual impact on total Medicare revenues will be different from those shown in Tables 86 through 89. Due to the limitations above, there is considerable uncertainty around CMS' estimates that is difficult to quantify in detail.

[Regulatory Review Costs \(p. 753\)](#)

CMS assumes that the total number of commenters on last year's proposed rule will be the number of reviewers of this proposed rule. ***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.

Using the [wage information from the BLS for medical and health service managers](#) (Code 11-9111), CMS estimates that the cost of reviewing this proposed rule is \$105.16 per hour, including overhead and fringe benefits, which CMS assumes is 100% of the hourly wage. Assuming an average reading speed, CMS estimates that it would take approximately 11.5 hours for the staff to review half of this proposed rule. For each commenter that reviews this proposed rule, the estimated cost is \$1209.34 (11.5 hours x \$105.16). Therefore, CMS estimates that the total cost of reviewing this proposed rule is \$4,873,360 (\$1209.34 x 4,000 reviewers). CMS estimates that the incremental costs of reviewing this proposed rule are the same as the CY 2017 QPP final rule.

[Accounting Statement \(p. 754\)](#)

As required by [OMB Circular A-4](#), CMS has prepared an accounting statement, which is reflected in [Table 90](#). [Table 90](#) includes CMS' estimate for MIPS payment adjustments (\$173 million), the exceptional performance payment adjustments under MIPS (\$500 million), and incentive payments to QPs (using the range described in

the preceding analysis, approximately \$590-\$800 million). However, of these three elements, only the negative MIPS payment adjustments are shown as estimated decreases.

[Table 91](#) summarizes the regulatory review costs, the collection of information burden costs, and expected benefits associated with this proposed rule.

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. <u>Denominator:</u> 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. <u>Numerator:</u> The number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.	No change	No change	Proposed exclusion: <i>Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.</i>
Patient Electronic Access	The MIPS eligible clinician provides patients (or patient-authorized	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	No change	Beginning with the 2018 performance period, CMS proposes to define “timely” as within 4 business days of the	No exclusion

2018 ACI Objective	Objective Details	2018 ACI Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion
	representative) with timely electronic access to their health information and patient-specific education.		<p>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 (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the MIPS eligible clinician’s CEHRT.</p> <p><u>Denominator:</u> The number of unique patients seen by the MIPS eligible clinician during the performance period.</p> <p><u>Numerator:</u> 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.</p>		<p><i>information being available to the MIPS eligible clinician. This definition of timely is the same as CMS adopted under the EHR Incentive Programs.</i></p>	
		Patient-Specific Education	<p>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.</p> <p><u>Denominator:</u> The number of unique patients seen by the MIPS eligible clinician during the performance period.</p> <p><u>Numerator:</u> The number of patients in the denominator who were provided electronic access to patient-specific educational resources using clinically relevant information identified from</p>		No change	No exclusion

2018 ACI Objective	Objective Details	2018 ACI Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion
			CEHRT during the performance period.			
Coordination of Care Through Patient Engagement	Use CEHRT to engage with patients or their authorized representatives about the patient's care.	View, Download, or Transmit	<p>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. 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).</p> <p><u>Denominator:</u> Number of unique patients seen by the MIPS eligible clinician during the performance period.</p> <p><u>Numerator:</u> 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.</p>		<p>Proposed change to the measure:</p> <p><i>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 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 (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).</i></p> <p>CMS proposes this change 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 would align the measure description with the requirements of the numerator and denominator. CMS proposes this change would apply beginning with the performance period in 2017.</p>	No exclusion
		Secure Messaging	For at least one unique patient seen by the MIPS eligible clinician during the performance period, a secure	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
			<p>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).</p> <p><u>Denominator:</u> Number of unique patients seen by the MIPS eligible clinician during the performance period.</p> <p><u>Numerator:</u> 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.</p>			
		Patient-Generated Health Data	<p>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.</p> <p><u>Denominator:</u> Number of unique patients seen by the MIPS eligible clinician during the performance period.</p> <p><u>Numerator:</u> 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.</p>	No change	No change	No exclusion
Health Information Exchange	The MIPS eligible clinician provides a summary of care record when	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	<p>Proposed change to the objective:</p> <p><i>The MIPS eligible clinician provides a summary of care record when</i></p>	<p>Proposed change to the measure:</p> <p><i>For at least one transition of</i></p>	<p>Proposed exclusion:</p> <p><i>Any MIPS eligible clinician</i></p>

2018 ACI Objective	Objective Details	2018 ACI Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion	
	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 clinician into their EHR using the functions of CEHRT.		<p>clinician (1) creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.</p> <p><u>Denominator:</u> Number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the transferring or referring clinician.</p> <p><u>Numerator:</u> The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.</p>	<p><i>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.</i></p> <p><i>CMS inadvertently used the term “health care clinician” and proposes to replace it with the more appropriate term “health care provider”. CMS proposes this change would apply beginning with the performance period in 2017.</i></p>	<p><i>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.</i></p> <p><i>CMS inadvertently used the term “health care clinician” and proposes to replace it with the more appropriate term “health care provider”. CMS proposes this change would apply beginning with the 2017 performance period.</i></p>	<p><i>who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.</i></p>	
		Request/Accept Summary of Care	<p>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.</p> <p><u>Denominator:</u> 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.</p> <p><u>Numerator:</u> Number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the clinician into the CEHRT.</p>			No change	<p>Proposed exclusion:</p> <p><i>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.</i></p>
		Clinical Information Reconciliation	Clinical Information Reconciliation Measure: For at least one transition of care or referral received or patient				No change

2018 ACI Objective	Objective Details	2018 ACI Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion
			<p>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 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.</p> <p><u>Denominator:</u> 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.</p> <p><u>Numerator:</u> 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.</p>			
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	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) ²⁸ .	No change	No change	No exclusion

²⁸ 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
	meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.	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.		<p>Proposed change to the measure:</p> <p><i>The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data.</i></p> <p>CMS proposes this 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. The proposed change aligns with the measure description finalized for Stage 3.</p>	No exclusion
		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 Proposed 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	<p>At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.</p> <p><u>Denominator:</u> 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.</p> <p><u>Numerator:</u> The number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.</p>	No change	No change	<p>Proposed exclusion:</p> <p><i>Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.</i></p>
Patient Electronic Access	The MIPS eligible clinician provides patients (or patient-authorized representative) with timely electronic	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	<i>CMS proposes 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</i>	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
	access to their health information and patient-specific education.		<p>eligible clinician’s discretion to withhold certain information.</p> <p><u>Denominator:</u> The number of unique patients seen by the MIPS eligible clinician during the performance period.</p> <p><u>Numerator:</u> 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.</p>	<p><i>final rule (81 FR 77228). It was CMS’ intention to 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).</i></p>		
		View, Download, Transmit (VDT)	<p>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.</p> <p><u>Denominator:</u> Number of unique patients seen by the MIPS eligible clinician during the performance period.</p> <p><u>Numerator:</u> 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.</p>		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)	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
			<p>during the performance period.</p> <p><u>Denominator:</u> Number of unique patients seen by the MIPS eligible clinician during the performance period.</p> <p><u>Numerator:</u> 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.</p>			
<p>Health Information Exchange</p>	<p>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.</p>	<p>Health Information Exchange</p>	<p>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.</p> <p><u>Denominator:</u> Number of transitions of care and referrals during the performance period for which the EP was the transferring or referring health care clinician.</p> <p><u>Numerator:</u> The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.</p>	<p>Proposed change to the objective:</p> <p><i>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.</i></p> <p>CMS inadvertently used the term “health care clinician” and proposes to replace it with the more appropriate term “health care provider” beginning with the performance period in 2017.</p>	<p>Proposed change to the measure:</p> <p><i>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.</i></p> <p>This change reflects the change proposed to the Health Information Exchange objective replacing “health care clinician” with “health care provider” and would apply beginning with the performance period in 2017.</p> <p>Proposed Change to the denominator:</p> <p><i>Number of transitions of care and referrals during the performance period for which</i></p>	<p>Proposed exclusion:</p> <p><i>Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.</i></p>

2018 ACI Transition Objective	Objective Details	2018 ACI Transition Measure	Measure Details	Proposed Change to Objective	Proposed Change to Measure	Proposed Exclusion
					<p>the MIPS eligible clinician was the transferring or referring health care provider.</p> <p>This change reflects the change proposed to the Health Information Exchange Measure replacing “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 proposes this change would apply beginning with the performance period in 2017.</p>	
Medication Reconciliation	N/A	Medication Reconciliation	<p>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.</p> <p><u>Denominator:</u> 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.</p> <p><u>Numerator:</u> 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.</p>	<p>Proposed objective:</p> <p><i>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.</i></p> <p>CMS proposes 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.</p>	<p>Proposed Modification to the Numerator:</p> <p><i>The number of transitions of care or referrals in the denominator where medication reconciliation was performed.</i></p> <p>CMS proposes 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. CMS proposes this change would apply beginning with the performance period in 2017.</p>	No exclusion
Public Health Reporting	The MIPS eligible clinician is in active engagement with a public health agency or clinical data	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	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
	registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.	Surveillance Reporting	engagement with a public health agency to submit syndromic surveillance data.			
Specialized Registry Reporting		The MIPS eligible clinician is in active engagement to submit data to a specialized registry.	No change		No exclusion	